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Children of Working Mothers
Expectant-Parent Classes
Parents of Child Amputees
European Child Research



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Tender loving care is the magic formula used by this nurse in Metera, a new children's institution in Greece for the temporary care of children awaiting adoption or foster-home placement. Each "mother-nurse" cares for no more than four children in order to have time to

attend to their emotional as well as material needs. The possibilities of helping children in institutions throughout the world are soon to be explored by the United Nations Children's Fund (UNICEF). (See page 114.)

For the past 7 years Eleanor Maccoby has been participating in Harvard's researches in child development and lecturing to Harvard and Radcliffe students in the university's Department of Social Relations. She was formerly study director for the Division of Program Studies, Department of Agriculture, and for the Survey Research Center at the University of Michigan, where she received her doctorate. She is coauthor of "Patterns of Child Rearing," by Sears, Maccoby and Levin, Row-Peterson 1957.



The project for training nurses to lead parent-education groups Aline Auerbach describes is one of a series for various professional groups she directs for the Child Study Association. Other projects have focused on caseworkers, groupworkers, community organizers, educators of various types, and clergymen. A graduate of Barnard College with graduate study at Columbia University's Teachers College and New York School of Social Work, Mrs. Auerbach has worked extensively with parents, individually and in groups.



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A New Zealander by birth, Harben Boutourline Young took his medical degree at the University of London. After wartime service with the British army and a residency in pediatrics in London, he came to the United States to become research associate at the Boston Lying-In Hospital. In 1950 he joined the staff of the Department of Physiology, Harvard School of Public Health. Since 1952 he has been directing the Harvard study of Italian boys described in his article.



Prior to coming to the Children's Bureau a year ago Michael J. Begab directed social services at the diagnostic center of the State school for mentally retarded at Columbus, Ohio. Previously he served in a similar capacity at Ohio's institution for the criminally insane at Lima. A graduate of the School of Social Service Administration, University of Chicago, he has also worked with mentally retarded children in Wisconsin and with emotionally disturbed blind persons in Illinois.



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CHILDREN AND WORKING MOTHERS

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INCREASINGLY, women with young children are taking jobs which take them away from their households during the day. What are the effects upon their children? Must we expect repercussions in the children's emotional, intellectual, or moral development? Is there any relationship between maternal employment and the incidence of juvenile delinquency or school-adjustment problems? Or does the mother's working stimulate the child, by example, to a greater interest in job achievement?

Actually, the fact that his mother works outside the home is but one of many factors bearing upon a child's development. We know little about its importance in relation to such other factors as the child's inherited intellectual and physical capacities, his parents' emotional stability, the type of community in which he is being raised, and the size and composition of his family. The effects of the single factor, *maternal employment*, if any, may be small, and they will not be the same on all children. What happens to the child will depend upon the effects of other factors interacting with the effects of the mother's absence from the home.

Juvenile Delinquency

A positive relation has been widely assumed between mothers' working and juvenile delinquency. Studies of groups of juvenile delinquents often show that a higher proportion of their mothers work than the mothers of children in the population at large.

However, most juvenile delinquents come from a stratum of society in which a mother's employment is likely to be an economic necessity. Possibly, at this economic level, an equally large proportion of mothers of children who have *not* become delinquent work.

In their study of 500 delinquent boys Sheldon and Eleanor Glueck provided a research control of such factors as economic level¹ by comparing the delinquent boys with a group of nondelinquents who were like them in intelligence, ethnic background, and age, and in the fact that they lived in underprivileged neighborhoods. The proportion of mothers who worked *regularly* outside the home was no different for the two groups. But the group of delinquent boys contained a larger proportion whose mothers worked *sporadically*.

On the surface this might suggest that if a mother wishes to work at all, she ought to work full time. But it may not be the sporadic absences which create adjustment problems for the children, but something about the family characteristics which led both to the mother's sporadic employment and her child's delinquency.

What were these "occasionally employed" mothers like? Many of them were women who had a history of delinquency themselves, and many were married to men who were emotionally disturbed and who had poor work habits. Commonly, the husband and wife were incompatible and each lacked self-respect. It is doubtful, therefore, whether the mothers' sporadic employment *as such* was conducive to delinquency in the sons; more probably the emotionally disturbed and antisocial characteristics of the parents

Based on a paper prepared for the National Manpower Council's conference, "Work in the Lives of Married Women," October 1957.

produced the mother's sporadic work pattern and at the same time led to delinquent tendencies in the sons.

The Gluecks' study includes data revealing the importance of the kind of supervision a mother arranges for her children while she is away at work. The accompanying table presents a recomputation of the figures presented in table 3 of the Gluecks' article, "Working Mothers and Delinquency."²

According to this study, if the mother remains at home but does not keep track of her child, he is far more likely to become a delinquent than if he is closely watched. Furthermore, if a mother who works arranges adequate care for the child in her absence, he is no more likely to be delinquent than the adequately supervised child of a mother who does not work.

Another study of delinquency³ compares a group of middle-class delinquent boys with boys similar in socio-economic status who were not delinquent. While both groups were small, and the differences between them in the rate of maternal employment were not statistically significant, there were, in fact, more non-delinquent than delinquent boys who had working mothers.

Middle-class mothers who go out to work are usually in a good position to arrange reliable care for their children.

Other Adjustment Problems

A number of studies have shown some association between maternal employment and adjustment problems of children. Unfortunately, in these such factors as economic status and emotional stability of the parents have not been held constant. In one study a group of adolescent girls whose mothers worked full time were compared with a group whose mothers did not work.⁴ In response to questionnaires, a greater percentage of those whose mothers worked than of the others indicated these problems:

1. An unwillingness to discuss their activities and their problems with their parents.
2. A feeling that their parents did not understand them when they *did* attempt to explain.
3. A feeling that their families did not have a "good time" together and that family meals were gloomy affairs.
4. Feelings of being rejected by their fathers and of shame at their fathers' behavior.

Since the two groups of girls were not matched according to economic level, we cannot tell whether

RELATION OF JUVENILE DELINQUENCY TO MATERNAL EMPLOYMENT AND QUALITY OF CHILD SUPERVISION

Supervision of child.	Mother's employment status					
	Housewife		Regularly employed		Occasionally employed	
	Good	Poor	Good	Poor	Good	Poor
Percent delinquent..	32	84	19	77	32	88
Number of cases....	457	149	82	110	89	116

To obtain these percentages, the 2 groups of children studied by the Gluecks (496 delinquent boys and a matched group of 497 nondelinquent boys) were combined into 1 population which was then subdivided on the basis of maternal employment and the quality of supervision provided for the child.

the majority of the working mothers came from the low-income population, where child rearing is somewhat less permissive and more punitive than in middle-income groups,⁵ and in which tension is more apt to exist between husbands and wives. Perhaps the attitudes of the daughters are a reflection of the interpersonal relationships in their homes.

Curiously enough the girls with working mothers seemed to have more disturbance in their relationship with their fathers than with their mothers. Possibly the mother's working in some way weakens the father's role in the family so that the daughter does not respect him as much as she might otherwise. An equally possible explanation, however, is that a number of the mothers are working because their husbands are unstable, a quality which might produce negative feelings toward a man on the part of both wife and daughter. Until we can compare families which are initially similar in paternal stability and economic level, we will not know the effect of the mother's working *per se* on adolescents' adjustment.

An interesting study on school adjustment problems⁶ was based on a number of children referred to a school-district guidance department for a variety of reasons, including school failure, aggressiveness, excessive withdrawal, and stealing. In this school district the large majority of the children of working mothers and also of those of nonworking mothers had never been referred to the guidance office at all. Among the children who had been referred, however, the children of working mothers were somewhat different from the children of nonworking mothers. The former were younger, and proportionately fewer of them were referred for academic failure and more for withdrawal tendencies.

Thus we have some slight evidence that in the small group of cases where the mother's working may contribute to school maladjustment, it is likely to do so at the time when the child first enters school, and that the child is more likely to suffer from a difficulty in relating adequately to other people than he is from academic failure. However, we do not know whether it is the mother's working which is behind the problems that appear, or whether both the problems and the mother's working are reflections of some other factor.

We know very little about whether the fact that a mother works stimulates her children to vocational achievement. Probably, much depends upon the nature and status of the mother's work. Perhaps the example of the mother's serious interest in outside work makes her children regard work highly. We do know that many men of achievement have had mothers who had flourishing careers or were otherwise active outside the home. We also know that high achievement motivation in children is often associated with the early application of parental pressure for independence.⁷

If mothers who work take special pains to train their children to do things by themselves, then their children might be expected to be especially self-reliant. However, if employment leads a woman to devalue her husband, then her son may be in conflict about the acceptability of maleness and may eventually find it difficult to succeed. Since we have no evidence for singling out the effect of a mother's working on her children's achievement, we can only suspect that much depends upon what the mother's motivation for working is.

Behavior Training

At all stages of their development, children require detailed training in major and minor skills as well as in moral standards.

Does a mother's working affect the quality and effectiveness of the training a child receives?

Child training is made up of thousands of episodes during which an adult caretaker distracts a child from undesired activity, interests him in desired activity, physically stops or prevents him from certain actions, guides his early attempts to acquire a skill, punishes or rewards a spontaneous action, or "reasons" with the child by making clear the possible consequences of certain actions.

What determines the effectiveness of these efforts?

First, the trainer must *be there* when significant events occur, to reward, punish, or explain. The bedtime comment, "You've been very good today," will please the child, but it will not help him to differentiate approved from disapproved actions. Second, the child learns more easily if the caretaker is consistent in her demands and reactions. Third, the caretaker's effectiveness depends in part upon the nature of her disciplinary measures. And finally, discipline is apt to be more effective if administered by a person with a nurturing relationship to the child.

The theory behind this last point runs as follows: punishment emanating from an individual whom the child does not love leads to fear on the part of the child and resultant efforts to escape or to conceal misdeeds. Punishment from a loved person, however, creates a different kind of problem for him: he wants the approval of the disciplinarian, and he cannot get it by running away, but only by conforming to her demands, by confessing and being forgiven, or by repairing the damage he has done. Ultimately, discipline administered by a loved person is more conducive to the child's internal acceptance of the values being taught him so that they become his own.

Experiments growing out of this theory have been done with animals.^{8,9} There is already some evidence for the following conclusion: When one attempts to train a dog to "resist temptation," the training is more effective if the person who administers it has previously had a nurturing relationship to the animal in puppyhood. Punishment by a stranger, or a person who has acted coldly or restrictively toward the dog as a puppy, does not so often produce the desired results.

If such experiments have relevance for humans, they would seem to indicate that the effectiveness of discipline administered to the child of a working mother depends upon the total relationship of the child with his disciplinarian. If his nurturing is divided between two people at different hours then discipline should be similarly divided. It would seem unwise for a mother to try to "make up" to the child for her absence by being so indulgent while she is with him that she does not exercise disciplinary control. Equally unwise would be a policy of delegating caretaking but not disciplinary functions to her substitute.

A primary consideration, therefore, is whether there *is* an individual who assumes full responsibility for training the child in the mother's absence. Among delinquent children are many whose mothers have not arranged for such care, leaving them to

roam the neighborhood unchecked after school hours. We can assume, however, that most working mothers try to arrange for some kind of substitute care.

What kind of substitute care is adequate from the standpoint of child training?

If the mothers remained at home they would vary widely in their training efforts. Some mothers do so much warning, explaining, guiding, and rewarding that their children become "overcontrolled," passive, and lacking in initiative. Other mothers interact with their children very little except when an emergency arises. A caretaker substituting for an overcontrolling mother would be unlikely to exercise as much control, unless she is a relative with similar traditions. On the other hand, a caretaker substituting for an aloof mother is apt to expend at least as much effort in child training.

In any case, the adequacy of the substitute caretaker depends not so much on the *amount* of control she exercises nor on *how* she does it, but on *how similar* her reactions are to those of the mother. For very young children a standard routine, even in minor matters, brings comfort and security. If the mother and her substitute adhere closely to the same routine and react similarly to the child's actions his learning task is simplified and his feelings of security enhanced.

As a child grows older he can begin to discriminate between what is expected by one person and what by another, and can adjust his behavior accordingly. By the age of 4 or 5 he can profit by beginning to have some experience in adjusting to the idiosyncrasies of different caretakers. Such experiences can prevent him from becoming rigid.

Ratio to Adults

Another important consideration is the number of children being cared for by one person. Many children of working mothers are left in day-care centers where the ratio of children to adults is high. In these the adults are usually so busy feeding the children, cleaning up, setting out play materials, and supervising group activities, that they have little time for individuals except when signs of trouble occur, and not always then.

In such settings, the children sometimes take over disciplinary functions, and scold or hit one another in an attempt to stop antisocial behavior.¹⁰

However, such reprisals are probably not as effective as those administered by adults. Moreover, the sanctions wielded by a child's peers do not always serve the values of adults.



The obvious warmth of this day-care-center teacher attracts these children like a magnet. Children lonely for their mothers often comfort themselves by clinging to a staff member. In the beginning some seek constant attention.

Group care, however, has some positive features. Often the persons in charge of children's groups are better trained, more patient, and more objective in dealing with the children than the mothers. A child can be allowed greater freedom to run, climb, and throw in a nursery school than in a home full of breakable objects. This greater freedom is reflected in the more rapid development of motor coordination in children in group care during the second year of life. But their lower level of individual interaction with adults is reflected in slower language development and toilet training.

True, these findings come from studies of children who have lived in groups almost exclusively and not of children who have spent about 40 hours per week in a group and the rest of their time with their families, as do children in day-care centers. It seems reasonable to conclude, however, that if the children of working mothers are cared for in groups during the day, certain features of behavior training may not proceed as smoothly as they might with individual care; but that they may derive some benefits from the experience of sharing with other children, and some stimulation from the variety of playmates, the freedom of movement, and the caretaker's skill.

Is the kind and duration of separation involved in a mother's working sufficient to produce trauma in a child?

From the work of such pioneering researchers as René Spitz,¹¹ John Bowlby,¹² Anna Freud,^{10, 13} and W. Goldfarb¹⁴ we know that:

1. Some young children, when separated from their parents for a week or longer go into a depressed, withdrawn, apathetic state from which it is difficult to rouse them. When they are reunited with their parents they do not recover at once from their grief, but become excessively "clingy" and suffer sleep disturbance.

2. Children vary greatly in their vulnerability to separation trauma.

3. Very young infants show few effects from separation. Children between 1 and 3 years are most vulnerable. Older children can begin to understand a little about the reasons for the separation and can be comforted by a promise that it will not last long.

4. While the most severe effects have resulted from separations lasting for a week or longer, many young children show disturbance of a lesser degree on very brief separation, such as when their parents leave them with a sitter for an evening. Commonly, however, such disturbance disappears shortly after the parents are out of sight.

Lasting damage to the child has been alleged to have been brought about by long-continued "maternal deprivation," especially among children institutionalized for the first years of life.¹⁴ However, the child of a working mother does not usually suffer this degree of maternal deprivation, if any. He has the attention and love of his mother during a predictable portion of his waking hours, and in her absence he has the attention, and perhaps love, of her substitute. Unless he is cared for in a large group during the day and neglected grossly by his mother in the evening, he would not be likely to undergo the kind of deterioration observed among institutional children.

The problem for children of working mothers seems to lie in the area of separation anxiety. Is the child made anxious each day when his mother goes off to work? Does he feel rejected, abandoned? If so, are there lasting effects? We actually know very little about these questions, though we can point to a few relevant observations.

In Okinawa, the mother of a young child customarily goes to work in the fields during the day. In her absence, the baby is cared for by a grandmother or an adolescent girl until school is out. Then a girl between the ages of 6 and 12 puts the baby on her back, in a sling, and carries him there through all of her afterschool activities until the mother returns home from the fields.

Okinawan babies seldom cry when their parents go off to work in the morning, but they *are* upset by "back-weaning"—by being told that they are too old to be carried about constantly any more.

This example suggests that young children can easily adjust to caretaking divided between the mother and some regular substitute. It also suggests that perhaps the child's adjustment is made easier: (a) if this division of responsibility is a common practice; (b) if the mother's daily departure is begun in the child's infancy, rather than after the child has become accustomed to a single caretaker; and (c) if the substitute has child-care techniques like those of the mother.

Perhaps if the child is cared for by a number of familiar adults the affectional relationship between mother and child will be less intense—as it is in large families where the child interacts with his brothers and sisters more than with his parents. Such attenuation of the mother-child relationship may not necessarily be harmful, but it probably produces a different kind of personality than an exclusive mother-child relationship.

A study in England compared observations of two groups of 2-year-old children during 3-week periods; one group temporarily staying in a residential nursery, and one group in a day-care nursery.¹⁵

Some of the findings were:

1. On their first day in the nursery, both groups of children cried a lot for their parents. As time progressed, however, this type of crying practically disappeared among the day-nursery children, who were satisfied to ask about their parents in order to be assured that they were coming back. The children in residence, however, continued to cry frequently for their parents.

2. The day-nursery children sought substitute attention in a matter-of-fact way (such as attempting to be near the observer) while the residential children sought direct evidences of affection, such as insisting on being held, and accompanied their seeking by crying.

3. The residential children showed increasing signs of severe hostility. The day-care children expressed a normal amount of hostility.

4. The day-care children continued to be eager to see their parents at the end of the day. The residential children cried when their parents visited and some failed to recognize their parents.

These findings suggest that, while there is an initial disturbance for the young child when a working mother first leaves him with a substitute caretaker for part of the day, he adjusts quickly to the new routine and appears able to maintain a close affectional relationship with his mother. Long separations, however, are much more disturbing and the disturbances may continue beyond the time when the child is reunited with his family.

Identification

On the other hand, there may also be danger in *not* separating mother and child often enough or early enough. It is possible for the dependency bond to become too strong, particularly if the mother has certain neurotic needs that she works out through a "smothering" attachment to the child.¹⁶ A cross-cultural study of male initiation ceremonies at puberty has indicated that a too-strong dependency bond between mother and child may generate certain strains which require the family to undergo great stress in the process of the child's achieving independence.¹⁷ If a mother works away from home, the process of gradually loosening her children's dependency bonds may be simplified.

Much of what an individual becomes, according to psychoanalytic theory, derives from the degree of success with which he can, in early childhood, pattern himself upon his parents. Does a mother's working interfere with the orderly development of identification, and if so, with what consequences?

Any discussion of the relationship of maternal employment to a child's ability to "identify" with parental figures must proceed on shaky grounds. Students of the topic have reached no generally agreed upon definition of the concept, "identification," and have only begun attempts at its measurement for research purposes.

We can, however, assume that one way in which children build up values and develop styles of behavior is by patterning themselves on a model. Although psychoanalytic theory has emphasized the importance of the same-sexed parent as such a model, the child can and does identify with more

than one person, incorporating values and habits of behavior from a number of sources.

Though affection may be one of the prime factors stimulating identification, enough examples exist of a child's adopting the characteristics of a strong though cold or hostile figure in his life to indicate that *power* may be even more important than love in this regard. That is, the child will generally identify with the person or persons having closest control over his destiny.

How would the fact that a mother works be likely to affect her children's identification with her? The answer probably depends in part upon the mother's relationship with her substitute. If the mother delegates child care to a servant who clearly respects her authority, the child will probably identify more with the mother than with the servant as soon as he is able to perceive where the source of authority lies. On the other hand, if the mother leaves her child with a day-care-center teacher who thinks of herself as more expert about child rearing than the mother, the child will be likely to pattern himself on the teacher. If care is divided between equal-status relatives, the child will probably incorporate behavior patterns from each.

Anna Freud and Dorothy Burlingham report some instances in which they believe division of identifica-

This 3-year-old in a day-care center is surmounting the difficulties of shoe tying. Does the seriousness of his expression come from complete absorption in his task or does it reflect a bit of after-nap loneliness for his mother?



tion generated conflict in children of 2 and 3.¹⁰ In one, a mother on periodic visits to her little girl in a residential nursery scolded her harshly. After these visits, the child would treat her doll in the same harsh manner, but as time passed, would revert to acting out in doll play the more patient care which was characteristic of the nursery "housemother."

The same kind of conflict arises, presumably, when a child's parents differ widely in their ways of reacting to him. However, incorporating divergent values may not always be worse for a child than incorporating a single set of values. In the example given, the child may have been better off with the conflict described than she would have been if she were exposed exclusively to her mother's harsh treatment.

For healthy development, children, especially boys, need a strong masculine model. We have already noted that disturbance in the father-child relationship sometimes coincides with the mother's working and that the mother's working itself may have resulted from a family-relationship disturbance.^{2,4}

What effect would the mother's working be likely to have upon the children's ability to identify with their father?

On the one hand, the dilution of the relationship between the mother and the children brought about by the mother's daily absence from home gives the father an opportunity to interact with the children nearly as much as the mother. On the other hand, the very fact that the mother works may detract from the husband's status in the eyes of the children.

It does not necessarily follow that the mother becomes dominant, or that the father suffers loss of status when the wife works. Where a good relationship exists between husband and wife, neither parent need be devalued in the eyes of the children. Whether or not the mother works is less likely to determine her husband's stature as an identification model for the children than the amount and kind of interaction between the father and the children, his own self-esteem, and the wife's underlying attitude toward him.

Clearly no single way of organizing family life is best for all. Some mothers should work while others should not.

When the mother works, outcome for the children will depend upon many factors: the age of the children, the nature of the mother's motivation to work, the child-care skill of the mother and of her substitute, the composition of the family, the stability of the husband, and the pressure or absence of tension between the parents. We cannot yet specify just how these factors influence the impact upon children of the mother's working. The necessary factfinding has only just begun.

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¹² Bowlby, J.: *Maternal care and mental health*. World Health Organization Monograph Series No. 2, Geneva, 1952.

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*Group participation is stressed
in training leaders for . . .*

CLASSES FOR EXPECTANT PARENTS

ALINE B. AUERBACH

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FOR SEVERAL YEARS the Child Study Association of America has been carrying on a series of experimental training programs for nursing personnel in leadership of parent and expectant-parent groups. With aid from the Children's Bureau, these programs have been conducted for nurses in the State health departments of New York and New Jersey.¹ They have especially emphasized one method, the use of group-developed discussion in conducting parent-education classes.

Many nurses find it difficult to develop participation as an important part of group learning, as the approach it requires is markedly different from the more traditional curriculum-centered approach, though the goals are in many ways the same. The differences lie first in the nature and scope of the subject matter discussed and second in the teaching method used.

Our groups for expectant parents meet for 6 to 8 sessions. Some are for mothers only; some for fathers only; and some for couples. As with traditional classes, their purpose is to give the members added understanding of the physical aspects of pregnancy and to prepare them for labor, delivery, and the care of the newborn. The distinctive addition is that in these groups the participants gain an understanding of the psychological and emotional reactions of themselves and their mates to

the pregnancy and to the coming of the baby and look at the fears, fantasies, and expectations that often arise during this period, checking them as far as possible with reality.

In many meetings conducted in the traditional manner much of this "emotional" material is brought out, but usually not until the question period following the formal talk. Sometimes it is expressed around the edges of the meeting, being directed to the leader before or after the session or to other group members in undertones during the discussion or over coffee cups afterward. The difference in discussion groups of the kind we are describing is that the group members are not only allowed but encouraged to present what is on their minds for honest appraisal by and sharing with the other members. Thus the expression of ideas and feelings becomes a legitimate, important part of the content the expectant parents discuss along with the facts they also are seeking.

The Method

The content of the meetings is not planned ahead in an outline or curriculum. It grows out of the group members' interests and concerns as revealed in their discussions. The material is developed through group discussion during the entire session and not merely in a question-and-answer period following a talk. The leader helps the members to share and balance their ideas, experiences, and anticipations, to focus the discussion, and to explore the topics from many different aspects, and then

Based on a talk presented at Army Health Nursing Workshop, Walter Reed Army Institute of Research, Washington, D. C., December 12, 1957.

adds information which the parents do not have. The leader does not tell the group what she thinks they ought to know without first finding out: (1) the extent of the information they already have; (2) what it is they really want to know; (3) the level of their learning and of their ability to add to their understanding; and (4) their response to the particular topic under discussion. Since the teaching material is not prepared in advance, the teacher must have a fund of knowledge to draw on as the group presents topics for discussion.

It is part of the leader's responsibility to give the group at some point the opportunity to talk about questions which she knows from her professional experience expectant parents usually want to explore. If the participants themselves do not bring up these subjects, the leader suggests them, giving the group the freedom to discuss them as far as they like or not to discuss them at all.

We have found that when a leader has pointed such questions out to a group, the members usually have responded to her lead, though not always along the lines or with the same detail that she has expected. If, for example, a group has not discussed the sequence of labor and delivery by the fifth or sixth meeting, the nurse-leader *must* point out that as yet no one has expressed any interest in this part of the coming experience, an aspect which interests most groups of expectant parents. By thus encouraging the group to talk about the subject, she may indirectly help the parents to overcome a possible reluctance on their part (she does not, however, discuss this reluctance directly with them) and open the way for a helpful discussion.

If the participants do not follow her suggestion, the leader respects their decision, but thinks carefully about what may lie behind their hesitancy and how she may help them to overcome it. In practice we have not known any group of expectant parents to complete its sessions without some discussion of labor and delivery. All the other major areas of interest are usually also brought into the discussion, although they are not all pursued to the same extent or developed in the same way from group to group.

This brief description of the discussion-centered focus of group education for expectant parents indicates how this method differs from other kinds of group teaching. It differs from the more traditional, didactic approach in not concentrating on imparting a fixed body of information as outlined in a set curriculum. It differs from some other

types of group discussions in making special use of the group process and group techniques in relation to one specific and important part of the participants' experience—their preparation for the birth of a new baby and for the resulting changes in their lives.

The nature of the subject matter calls for a kind of leadership skill that is different from that required for staff education, for social action or for other functions carried out through groups. The primary purpose is not to give the members a better understanding of one another (though, hopefully, this might be a secondary result) nor is it to come to agreement or consensus on the topic under discussion. The primary purpose is to help the participants to acquire a better understanding of the situation which has brought them to the group, so that each may be prepared for the new experience and better able to do what he or she feels is right.

Groundwork for Discussion

Participation in this kind of group discussion is important, but not as an end in itself, as it is in certain types of group work which have a primary aim of improving each participant's performance as a group member. When the discussion is developed chiefly from the ideas contributed by the group, participation furnishes the clues to the members' interests and needs. It starts the discussion at these points and supplies the groundwork on which the members can build a wider range of information and a richer understanding of themselves and the situation they are facing.

Participation is also the path through which the group member channels and expresses his involvement with the subject matter and with the group. The expectant mother learns from the beginning that she can freely express whatever she is thinking or feeling—her doubts and uncertainties about herself, her need for information, her own and her husband's ideas about how long he will stay with her during labor, their ideas about "natural childbirth," their anxieties about their ability to take adequate care of the baby, or whatever else is on her mind. Each participant finds that he is being listened to and that he is playing an essential role in determining what the group will discuss, even though the leader's purpose is to effect a broadened understanding in the group as a whole about matters of common concern. Because they function actively the participants come to feel that the group is theirs.

Expectant parents come to these classes because

they feel a strong personal need for a better understanding of what they face. They want more knowledge about all aspects of their approaching parenthood to help them go through labor, delivery, and the postpartum period with a minimum amount of fear and with confidence and competence. They become intensely absorbed in the discussions as they learn through experience how all the participants' needs are met, and especially their own. They talk about the fact that they look forward from week to week to see how the discussion develops, as if it were a continued story. They are a part of it, and behave quite differently from expectant parents who come to sit passively listening to a lecture which they can attend now or in six weeks time when the next course gets around to the same point.

The Leader's Considerations

The foregoing should not be interpreted to mean that each person does or even should participate in the same way or to the same extent. The leader does not put any pressure on the group members to talk and is careful not to make them feel self-conscious about how much they participate in the group. However, the leader does try to encourage each person who is ready to speak out to do so and, at the same time, to help the too-active participants to learn to listen and to give the others a chance.

People learn at different speeds and in many different ways. Some expectant parents "participate" very little in the sense of talking. Yet they may be learning as much as the others by listening and by thinking things out. Their facial expressions and body postures often reveal the extent to which they are "with the group."

Building the subject matter from the expressed interests of the group members has many other advantages. It enables the participants to discuss what is really on their minds rather than what the leader thinks they should know. It keeps the discussion close to their real experiences, rather than off somewhere on a general, intellectualized plane. Yet this does not mean that the discussion will not reach some basic generalizations. Some discussions have started with such specific points as the discomfort of an expectant mother in her seventh month of pregnancy and have proceeded logically from the reasons for her feelings of physical pressure to a review of what has gone before in the growth of the baby, as well as to a look ahead at what is to come—thus producing a better understanding of the total birth process.

The leader must consider carefully what parents

may really be asking when they introduce a subject for discussion. She needs to find out what they already know about the topic or what they have been thinking about it. This type of awareness accomplishes several objectives: (1) it keeps the leader from letting the talk go off on a false track; (2) it helps her to draw out the members' experiences so that she can sense what they already do know and not waste time by unnecessary repetition; (3) it gives her an idea of the degree of the group's readiness to move into the subject under discussion; and (4) it clarifies the concern that prompted the question or expression—not always evident at first.

Encouraging group participation is particularly effective in getting at "the question behind the question," which the questioners themselves may not have seen clearly. These underlying concerns come out best when the participants in the discussion have time and "room to move around in," as one nurse has said. The introduction of the topic of natural childbirth, for example, often seems like a simple factual opening. When it is explored further, it may reveal all manner of confusions as to what the term really means as well as anxieties about the experience of delivery itself and the mother's tolerance and fear of pain. Questions about formula preparation, important though they may be in showing the young expectant mother's need for practical information and help, may also be the indirect expression of conflict and confusion over the choice of breast or bottle feeding—a subject which the group needs to talk through from all points of view.

Gearing the discussion to the interests and readiness of the group, as revealed by the members' questions and remarks, tends to make the group experience more meaningful to the participants. Dr. Gerald Caplan² and other observers of the emotional and psychological aspects of the pregnancy period have described the typical mood swings and shifts of interests of pregnant women. These challenge the traditional teaching procedures. If, for example, expectant mothers are absorbed in themselves during the early months of pregnancy, focusing on their own bodily changes while they are struggling to understand what the coming of the baby really means to them and to their own feelings of adequacy, why should they be expected at that time to discuss the details of the delivery or the care of the newborn? Would it not be better to let such a discussion come at a time when their interest turns naturally to these subjects, as it usually does later in pregnancy?

Such considerations involve the question of the groups' composition. Should each group include only women (and their husbands, if it is a couples' class) who are at approximately the same stage of pregnancy? Our experience has revealed no definite answer to this question. It has shown that groups so formed have both advantages and disadvantages. While the members of such a group could be expected to have more similarity of interests than a less homogeneous group, the latter is apt to have a wider range of ideas and experiences to stimulate the discussion. In any instance, the leader must not only be aware of the predominant interest of the group but also recognize individual differences and at times point them out.

The Expression of Feelings

Another value of group participation lies in the opportunity it provides for the expression of feelings along with the need for facts. Many of these young expectant parents never have the chance to express these feelings. These remain bottled up and may become a core of resentment or irritation which hinders objective thinking.

Take, for example, the subject of nutrition during pregnancy. Our experience has indicated that expectant-parent groups rarely are interested in or feel the need for more information on the "basic seven" food categories. The members get this information from their doctors, from clinic personnel, or from printed material. What many expectant mothers do want from the group, however, is a chance to express their resentment at having to stick to a diet at the very time when they want to eat more and to be indulged and coddled rather than deprived.

After they have voiced their reactions, sympathized with each other, and obtained sympathy from the nurse-leader as to their food difficulties, these young women seem relieved and able to look at the situation more objectively and to see that their own interest as well as the baby's will be furthered if they follow the nutritional suggestions. They become more resourceful about making adequate substitutions for foods they really dislike and accept such ideas readily from one another. Especially important is the achievement some of them make in being able with little or no resentment to serve their husbands foods forbidden to themselves.

It also helps the participants greatly when they express their feelings in the group on many other subjects, when others listen with respect, and when they learn that it is not unusual to have such feelings, both positive and negative. On occasion they even express some of their mixed feelings about the new baby, and learn with surprise and relief that other expectant parents also wonder at times if they really want the baby after all. This may be true even of those who wanted a baby desperately and are in the main deeply gratified and proud that he is "on the way."

Looking at one's own feelings frankly within the safety and protection of the group seems to be the first step in putting them into a proper perspective.

Another point about the value of participation has to do with the interaction between the participants as a result of the group experience. This calls for a look at the way expectant parents make use of the group for their further growth and learning. They gain strength first from the group's support, from learning about others who are "in the same boat," who are thinking and feeling in much the

A group of parents meeting with a nurse (third from right) in a Child Study Association project to discuss their problems.



same way about their common experiences. They gain strength too from the interchange with one another. This the nurse-leader can consciously direct toward what for many may be a new kind of understanding—an awareness of differences in ways of reacting toward experience, differences which come from variations in personality, background, and life experiences.

It is these differences, thoughtfully considered in the group discussion, which open the way for different choices of action. Whether parents do or do not choose natural childbirth or rooming-in (where a choice is possible), breast feeding or bottle feeding, whether or not they decide to have their mother or mother-in-law help after they bring the baby home, whatever the area of decision, the important point is that they should have been helped to look at all the issues involved so that their choice is sound for them.

Some Other Questions

We have frequently been asked about the use of demonstrations (the baby bath, formula preparation, and layette) and of visual-aid materials in programs for expectant parents. In our groups we follow no fixed procedure except that of trying to meet the needs of the participants as flexibly as possible. Demonstrations can serve a real purpose in giving expectant parents an idea of something practical they can do, even if they forget completely what they have seen and learn all over again by doing after the baby is born. Such demonstrations can be helpful if they are not offered rigidly as the one way of meeting the situation, but rather are presented creatively, as a springboard for comments and questions from the expectant parents which can be built into the discussion.

Visual materials such as the Birth Atlas can be used flexibly, too, to illustrate points raised in the sessions, without laboring them or following them through to the last detail. Nurses who have

watched the reactions of group members to the Atlas' pictures report a wide variation of responses. Some people are fascinated by them, and find them not only helpful but beautiful; others find them too realistic and frightening and look the other way. Almost universally, the nurses in our project found that these materials were more effective if they were used selectively and briefly.

The foregoing is only suggestive of some of the adaptations of teaching methods that can be made in a program based on group participation. Teaching of this kind obviously requires knowledge of both subject matter and the techniques of working with groups. The latter is as yet difficult to acquire as a part of nursing education. Individually many nurses are reaching out in their own communities for help along these lines and are experimenting with new approaches on their own initiative.

Question has been raised as to whether every nurse should be expected to conduct classes of this kind. In our experience, some nurses do not seem suited to this type of work; others develop amazing skill and sensitivity with extra training and with the added help they can be given in practice groups under skilled supervision.

The majority of nurses with whom we have been privileged to work have found this approach stimulating and revealing. Even those who, for various reasons, are not conducting their classes exactly along these lines have said that their experience with group discussion for expectant parents has given them a new knowledge and a greater capacity to listen. They also say they have gained a new awareness of their group members' needs which has permeated all phases of their work with patients.

¹ Auerbach, Aline B: Public health nursing and parent education: a pilot project of training for parent group leadership. *American Journal of Public Health*, December 1955. New approaches to work with expectant parent groups: a report on a pilot leadership training program for nurses. *American Journal of Public Health*, February 1957.

² Caplan, Gerald: Psychological aspects of maternity care. *American Journal of Public Health*, January 1957.

A pair of substantial mammary glands has the advantage over the two hemispheres of the most learned Professor's brain, in the art of compounding a nutritious fluid for infants.

Oliver Wendell Holmes in Medical Essays.

PARENTS OF CHILDREN WITH CONGENITAL AMPUTATION

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"IT DOESN'T SEEM to bother Tommy that he was born without a hand. He never mentions it."

As the social worker for the Child Amputee Prosthetics Project at the University of California, Los Angeles, it bothered me when I heard a mother make this statement. Social workers know that a child is concerned about being different from other children even though he may not express his feelings about this. At this project we have learned that the replacement of an arm or hand by a "good functioning" artificial one is not the sole answer to a child's problem and that his ability to use the prosthesis will be largely conditioned by his parents' attitudes.

In 1955 a grant to the university from the Federal Children's Bureau assured the continuance and expansion of an interdisciplinary approach to prosthetics planning with child amputees and their families. Physicians, prosthetists, engineers, occupational and physical therapists, a psychologist, and a social worker came together as a team to learn what constituted a successful prosthetics experience—a well-made artificial limb (in this instance an arm), acceptable and useful to the patient.

The members of the disciplines within the project have sought to obtain information that would: (1) identify the various factors influencing prosthetics planning; (2) indicate methods of overcoming or modifying conditions that interfered with prosthesis acceptance; and (3) suggest the kind of program that could test results and be useful to other organizations working in the same or a similar field. This plan was

in keeping with Dr. Bechtol's suggestion that studies should be initiated to learn more about the full import of the loss of a limb to a patient and to his family.¹ Preschool-age children with upper extremity amputations and children with upper extremity malformations were given preference for inclusion in the study because little was known about their problems and the methods of dealing with them. The caseload at present includes approximately 130 children from the State of California.

Established on an outpatient basis, the project requires at least one parent to accompany each child and encourages other family members to participate in all phases of the program. Hospitalization is arranged for a patient when a surgical procedure is necessary. Families who live near the project come from their own homes. Those who live too far away to go and come in a day are housed in a nearby motel, with some of the cost borne by the project if the branch of the State crippled children's service in the family's home community corroborates the need for such assistance.

We have attempted to make the program a family-oriented approach to prosthetics planning, on the theory that the more closely the family unit can be maintained and used as a support for the child the less likely is his difference to dominate his personality and so become detrimental to his development.

Because 80 percent of the children who came to the project had been born with their amputation, we found we were working with parents who questioned their adequacy to produce a complete child, and with

children who could not find a satisfactory answer to the question, "What happened?" We suspected that such parents could not accept a substitute mechanical arm for their child if they continued to hope they would wake up from a nightmare to find that he had two perfectly normal hands. Because children tend to adopt the attitudes of their parents we could learn from the parents the child's degree of readiness to accept an artificial arm and be trained in its use.

The project provides time in each case for parent and child orientation and for professional evaluation before a final decision is reached on whether or not to prescribe a prosthesis. Parents and patient are introduced to the project facilities, procedures, and personnel by the administrator. For some parents this is the first time they have seen or even heard about the split-hook type of terminal device. Its appearance offends those who have need for a lifelike hand and sends some of them scurrying for reasons why their child has no need for a prosthesis. Others who may feel the same immediate repugnance to the prosthesis are more realistic about their child's needs.

Following the introduction to the project, the pediatrician examines the patient and obtains the family's medical history. While revealing family history bothers some parents it seems to give most of them a feeling of having something important to contribute to the project as well as to receive from it.

The day after the pediatric examination the social worker interviews the parents and the psychologist tests the child. The occupational therapist also interviews the parents, explaining the nature of the training program at the project and pointing out the importance of follow-up through a therapist in their home community. The parents are told that regular visits to the project will be scheduled 3 or 4 times a year for checking the fit and mechanical operation of the prosthesis and introducing new activities to help the child achieve greater use of the device.

Later, at a staff conference, the question of prescribing a prosthesis is considered in the light of the findings of the team members. Physical therapy or surgical procedures may be recommended prior to prosthetic fitting. The psychosocial factors are considered and therapeutic measures appropriate to the family's needs recommended.

Our experience indicates that readiness for a prosthetics program begins when parents sense they are making a contribution to knowledge through relating family history and participating in social-work and psychological interviews, and when they reveal a capacity to envisage the future through acceptance

of responsibility for providing continuity of training.

The Social Worker's Role

Social work in the Child Amputee Project is similar to social work in any medical setting, the case-work relationship being the medium for study, diagnosis, and social-work treatment. Through interviews in which facts as well as feelings and attitudes are elicited, the social worker gains understanding of the meaning of illness or disability to the patient and his family and of the patient-family relationships. On the basis of a social diagnosis a plan is made for meeting the social and emotional needs of the patient, his family, and others important to them, in relation to the child's disability, so that the patient might achieve maximum use of the prosthesis prescribed.

Specifically the social worker in the Child Amputee Prosthetics Project:

1. Evaluates the family's readiness to accept the prosthetics program; helps with problems which may interfere with the successful use of a prosthesis; and assists the parents in obtaining help in meeting other needs of the child or of themselves.

2. Functions as a member of the prosthetics team, contributing such information as is appropriate to a better understanding of the patient and his family and helping the family members to understand their relationship to the project and to the various members of the team.

3. Acts on behalf of the family as liaison with other social agencies, public and private, in helping the family gain the greatest benefit from the prosthetics program through the use of other appropriate resources.

The social worker's research goal has been identification of important psychosocial factors indicating a family's readiness for a prosthetics program.

Since social-work literature has little to offer in developing a study of parents of amputees, it was necessary to begin on an exploratory basis. Before setting up a specific research project, recordings of social-work interviews with a selected number of parents of 20 child amputees were reviewed. These interviews had been carried on in an unstructured manner to allow parents to express concerns about themselves, the project, the child, and the prosthetics device. On the basis of the findings of this review a pilot study was developed. This was limited to

new requests for admission to the hospital and involved the parents of 25 congenital amputees.

It was our impression that a family's general life pattern, experiences at the time of the birth of the patient, quality of relationships both in and outside the family group, the nature of communication among the family members, and the parents' capacity to involve themselves in a social-work interview had a direct bearing on the patient's readiness to proceed with a treatment program. In order to test this hypothesis we sought to identify in our analysis the parents' attitudes toward their child and his amputation, their reasons for coming for treatment, and their ability to accept help for the child and themselves.

Study Results

Following are some of the preliminary findings based on interviews with the parents of the 25 children with congenital amputation.

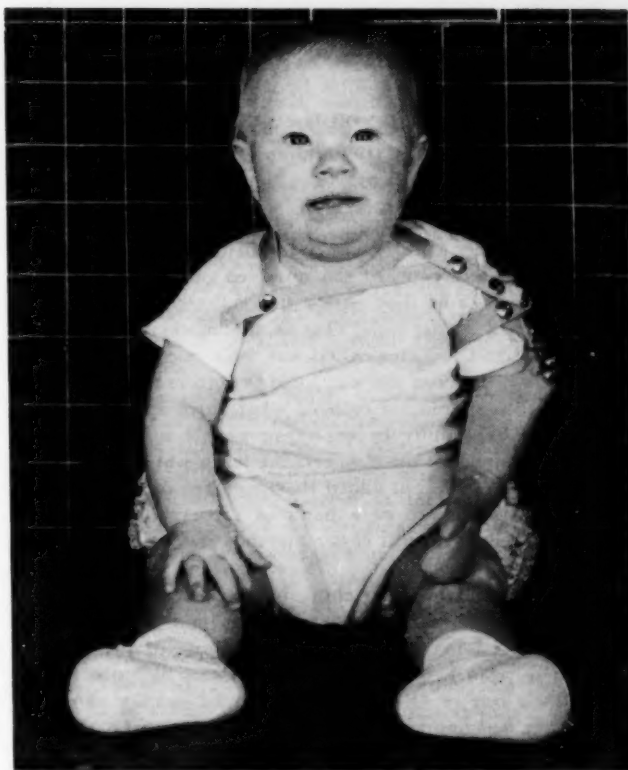
Parents apply to the prosthetics project for a variety of reasons and with varying degrees of understanding of prosthetics and of themselves. They can be classified into three groups:

1. Parents who have sufficiently coped with the traumatic experience of having given birth to a child with an anomaly to be able to discuss the disability realistically; who realize and accept the child's need for both independence and dependence; and who have so freed themselves from self-blame that they can communicate understanding to the child and be helpful to him with his own problems of being different from other children.

2. Parents who are bewildered by the problems that are created by a child who is different; who continue to be troubled by a feeling of having caused the anomaly; who express concern about the reactions of strangers, friends, and relatives to the amputation and to a prosthesis; but who have the strength to look at their reactions and concerns and to make use of help.

3. Parents who have attempted to absorb the child in their own needs and conflicts; or who have isolated the child through avoidance of communication or insistence upon complete self-sufficiency; or who have withdrawn from close association with the family by illnesses or flights into activity; and who in defense deny the need for help.

The birth of a child with a congenital amputation does not necessarily cause the family to adopt a new pattern of behavior, but more often provides



At 7 months of age this little girl wears a simple prosthesis which is used for two-handed holding and pushing.

the critical incident that reveals the ways the members of the family handle stress individually and as a group. The stress is sudden and brought about by an event which is irrevocable and loaded with notions of misdeeds and punishment. "What did I do wrong?" is an almost universal question of mothers of congenitally deformed children.

Sound planning for a prosthesis must include recognition of the responses of the child's parents to his amputation for they tend to repeat similar responses in varying degrees when they see their child wearing a prosthesis.

The children of the parents described in the following three groups all have a short below-elbow type of amputation.

Parents in Group 1

Parents in this group have been able to handle their feelings and are not inclined to dwell in their discussion on their possible responsibility for the malformation, on possible concealment of the amputated side, or on a resolve to act differently toward this child because they "did not give him a hand." These parents ask for help with specific

problems they recognize in the child and in themselves. They may, for instance, express worry about the effects on the patient's brother or sister of focusing so much attention on the patient. They are not so absorbed in their own needs that they cannot see the needs of others.

A mother in this group spoke of her immediate feeling of self-pity after her child Ricky was born. As she lay in her bed in the maternity ward she observed patients and visitors looking in at her as they passed down the corridor and was certain they were saying, "That is the mother of the baby without a hand." Later when she was permitted to walk around she discovered she was looking into each room as she went by. She thereupon realized what harm she could do to herself and her family by expecting people to point fingers at her. She spoke of the closeness she felt toward her husband before Ricky's birth, but added that from the moment he told her about the absence of a hand in the child their shared sorrow brought them still closer together and became a source of strength.

Ricky is not a compliant child, but a boy with energy and curiosity. His mother has learned when and how to loosen or tighten the reins and to distinguish those of his troubles which arise from being different and those which are typical of any little boy of 4. She told the social worker about incidents that had happened and how they were met. She also discussed the problems that Ricky might meet as his world expands. She knows her child is different because he has only one hand, but she has learned there are ways of keeping him from being overwhelmed by this difference.

Parents in Group 2

A majority of parents in the study were classified in the second group. These parents most often talked about problems which revealed inability to be consistent in discipline, overconcern about appearance, discomfort with the curiosity of outsiders, and difficulty in understanding their own feelings. Fitting and training were delayed for the children of some of these parents until the parents received help with their feelings and attitudes, so that they in turn could be more helpful to their children. So it was with Tommy, mentioned in the beginning of this article.

As Tommy's mother expanded on why she believed his lack of a hand did not seem to bother him, it became apparent that he was not the only uncommunicative member of the family. His mother and father had talked very little with each other about their feelings of being parents of a child born with an amputation. The mother expressed concern about the father, sensing his distress about Tommy's anomaly, but had not talked to him about it. On two occasions when she had seen Tommy crying after people had made remarks about his stump, she did not speak to him about these incidents and he never mentioned them to her.

The mother brought Tommy to the project when he was 10 because she thought he should learn to use a prosthesis at this

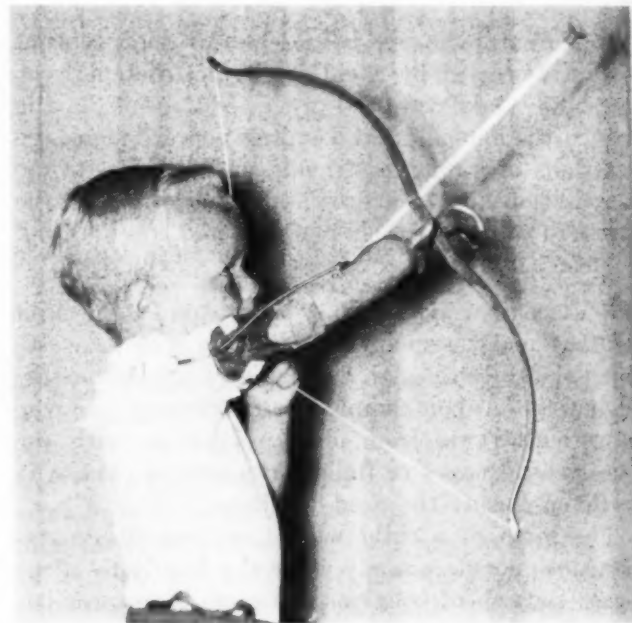
age in preparation for the day when he would need to be employed. Tommy would not talk about his amputation or the need for a prosthesis.

Following a recommendation that prescription for a prosthesis be delayed, casework with the mother was instituted. The focus was on helping her to communicate feelings to the social worker and to find ways of establishing communication with her son. At the same time Tommy had an opportunity to observe other patients being trained in the use of a prosthesis. After a few months Tommy requested an artificial arm and talked with his mother about some of the reasons for his desire. During the period when he was being trained in the use of his prosthesis, his mother and the social worker discussed ways of preparing his school for his appearance with it. Through this experience the mother found additional ways of communicating to her son her understanding of some of his difficulties.

Prostheses were recommended for the children of some parents in Group 2 with the understanding that the parents would receive casework help while their child received training. This was true of 4-year-old Sally.

Interviews prior to prescription with each of Sally's parents had revealed they had difficulty in setting limits for her and were preoccupied with her appearance. Although the mother could not talk about the child's birth, the father had graphically described his reactions: "I had to keep telling myself, 'she is my child and I have to make it somehow or another'." He also described how the mother cried when she came home with the baby and had looked in a closet at the dresses of Sally's older sister, remarking that Sally could never wear puffed sleeves, because everyone would see she had no hand.

The split-hook type of prosthesis, as worn by this 3-year-old archer, enables the child to hold and to manipulate.



During the training period, interviews with the father and mother revealed that their reactions to the prosthesis presented difficulties not too different from those experienced with the amputation itself. Frequently the mother asked if Sally should wear her prosthesis to this or that place, reflecting her concern about appearance. Although the parents said that their two daughters were handled in similar ways, they indicated that they felt guilty when Sally had to be punished, a fact which the child exploited.

The occupational therapist and social worker worked out a plan together to allow the mother to be present during the latter part of each training period only. The therapist was firm in her training approach with Sally. This plan worked effectively with Sally and although exclusion from the training room aroused the mother's anxiety, it helped her focus more quickly on her problem.

The mother continues to be concerned about appearance but has become less anxious about permitting Sally to make good use of the training program and about disciplining her. This latter gain has also helped the older sister's behavior.

The parents in the second group seem to believe they should not give vent to their feelings because they have been told so many times they should be grateful that the disability is no greater than it is. A mother of a 15-year-old boy expressed her reaction to the social worker. "For the first time since he was born, I feel I can let go and talk about me."

The families in this group have one important characteristic—at least one parent has the capacity to look at his reactions and make use of help.

Parents in Group 3

The parents of the third group pose problems in relation to themselves, the patient, and the project. Most of them have come to the project because they had been told they should do this to benefit their child. The need to assuage their guilt is so great they accept the referral.

The personality difficulties of many of these parents are so deep seated as to interfere with the effectiveness of working with the child. Some have so absorbed the child he cannot function independently of the parent. Some ward off professional help through a consistent depreciation of the services. Some interrupt or completely cancel their association with the project on the basis of their own ill health or other excuses.

These parents have so internalized their problem they cannot tolerate a program that is designed to deal realistically with the amputation. Those who have remained in the project have taxed the energies and skills of all the personnel.

Danny's mother explained in the initial review with the social worker that she experienced no shock when the doctor told her Danny had no hand. She told of seeing this con-

dition in a vision before he was born and said that she knew then that she would "be his other arm." She carried out her resolve to such an extent that at the age of 7 Danny did not share in any of the household tasks expected of his four older brothers and sisters and had been allowed to sleep with her almost every night since infancy. She described her anger when anyone brought up the subject of Danny's arm.

At 7 Danny acted like a 3-year-old. Psychological testing revealed that he was emotionally but not mentally retarded.

The team's decision to prescribe a prosthesis for Danny was made with full knowledge that its proper use might be impeded by the severe emotional problems in parents and child, and that these would have to be analyzed in an effort to find ways of dealing with them.

Attempts to involve the mother in casework interviews each time Danny came to the project for training bore little fruit until she expressed some concern about her son's continued desire to sleep with her. The social worker used this bit of anxiety to stimulate in her a desire to understand more about her child. When Danny showed signs of failing in school, the mother's anxieties became so acute that she was willing to accept a psychiatric referral. This was a full year after the prescription of the prosthesis. Until then Danny had made little use of the prosthesis although he and his mother had kept all their appointments at the project. Some progress is now evident, but the problem within the mother is of such long duration and Danny's emotional development so retarded that good prosthetic use cannot be achieved until the emotional disturbances have been ameliorated.

In dealing with parents in Group 3, the prosthetics project is faced with a major therapeutic problem. Recognition by a professional person that a patient needs psychiatric care does not mean the patient can accept this. Thus a few parents have refused to continue with the program and have terminated their contact during the orientation-evaluation period.

When this happens the project explains the fact to the State crippled children's service worker in the family's home community who may initiate there whatever services may be available, and whatever devices may be possible in helping the family move toward an acceptance of professional help. Our project is too new for us to be able to tell how many and how soon such parents may return to us for help. Some may reject any further contact with the agency that referred them to such a disturbing experience.

The children of some of these parents have had other physical conditions requiring treatment. One parent is receiving casework services in a cleft-palate program. In some cases the child's behavior at school has prompted the school to initiate help.

Discussion

Conceivably the parents in Group 2 would become more like those in Group 1 after, or if, they have

been able to achieve greater understanding of the cause of their reactions to their child's anomaly. Some parents of Group 3 may be able to effect some change within themselves, but the process of doing this will undoubtedly require a long time and in most cases the changes will be small.

The social worker's determination of the families' readiness to enter the prosthetics project helps the occupational therapist to plan programs differentially to meet the needs of individual children. Parents who have been freed from involvement with their own problems can be expected to grasp the intent of a training program and follow through with it at home. Parents who are still struggling with the question of whether the child should wear the prosthesis outside the home or at all are not able to turn their attention to the function of a prosthesis.

Evaluation of the potential of the patient and parents for prosthesis acceptance becomes critical when viewed in the light of the limited community resources for this type of care and the costs of such care. It is unwise to expend \$200 to \$500 for a

prosthesis when the family is not ready to accept the need for it. An initial failure with a prosthesis may make it even more difficult, if not impossible, for parents and child to achieve motivation toward prosthesis acceptance at a later date.

The Child Amputee Prosthetics Project is evaluating the methods that determine readiness and the factors within the patient and family that may contraindicate an immediate prosthetics program for the patient. This is but one of the many facets of the program and of the social worker's part in it. Few projects as extensive and intensive as this one are available throughout the country. However, if our findings on readiness are valid, projects of a more limited nature, supplemented by existing services within communities, may be able to use them in providing sound prosthetics programs.

Further research is necessary to find ways of helping many child amputees and their parents to a successful acceptance of prosthesis.

¹ Bechtol, Charles O.: Artificial limbs for child amputees. *Children*, May-June 1954.

We must encourage new explorations and not choke off speculations, guesses and hunches. It is out of such approaches that science grows. At the same time we should cultivate our observational abilities to evaluate new directions pointed out to us and be flexible enough to test them adequately. As Schilder said "If an idea sounds good it has a good chance of being right."

However, this does not mean that we should go off on tangents or be lured by wonderful sounding but unproved premises that can so easily become fashionable just because they are repeated in accordance with the white queen's statement to Alice—"If you say a thing three times then it becomes true." The exploration of new hypotheses may open many otherwise closed doors but we must recognize that most of them will have to be closed again.

Reginald S. Lourie, M. D., to the 1958 annual meeting of the American Orthopsychiatric Association.

EUROPEAN RESEARCH IN CHILD PSYCHOLOGY

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THIS REVIEW of current European research in child psychology is necessarily partial. It cannot pretend to approach a full description of the work going on in the 18 major countries of Western Europe and in those of Eastern Europe from which information can be obtained. It must of necessity dwell upon those centers of research which are of principal interest to the reviewer and to those who have counseled him.

European Trends

There is considerably more activity in Europe than there is in the United States in research on language development in children and in the mechanism of memory. The most productive recent research in problem solving and formation of concepts by children has come from Europe, especially from Geneva through the works of Jean Piaget and Barbel Inhelder. There is also a good deal of interest among European research workers in the interpretation of children's drawings.

On both sides of the Atlantic interest in the adaptation of the child to society is steadily growing. While the adjustment of the child to the accepted characteristics of the community in which he lives continues to receive attention, at the same time increasing effort is focused on finding ways of building healthy, independent individuals capable of creating the society of the future. The capacity of children to adapt to various cultural patterns seems to have been clearly demonstrated by several careful works in cultural anthropology, some of which have indicated that the children best adjusted socially

were also the most intelligent and came from stable homes. While these demonstrations are largely of American origin, the works of E. Boesch in Switzerland and of H. T. Himmelweit in England, among others, have also made significant contributions.

Considerable attention has been paid in Europe, as well as in the United States, to the function of independence. The results of experiments in the United States, France, and the Soviet Union appear to agree on the difficulties presented for the development of independence in some children by entrance into nursery school. Major work on the emotive problems of adolescence corresponding to puberal change is largely American, but Swiss and Russian workers, especially M. Debesse, G. Sobieva, and T. V. Dragounova, have also considered these problems as related to identification with others.

Mental Growth

A number of European studies of mental growth are currently under way. The Institute of Education of the University of Geneva has planned a longitudinal growth study to cover 3 years in the lives of 4 groups of children of overlapping ages, ranging between 5 and 14. A small number of children—20 in all, 5 in each age group—are being examined in regard to cognition, perception, and social interaction. This includes a number of possible tests for cognition, some tests for perception, and one or two for social interaction. Altogether about 40 tests are given to the children, about 20 for each age group, with some overlapping. Some tests are standardized but others are in an experimental phase.

This work at Geneva is important not only for the information which it will provide but also for the imaginative new procedures which are being developed. As yet there is no correlation with physical development, but information on the children's socioeconomic backgrounds is available. The work is being done by Barbel Inhelder and Gerald Noelting. The children are always seen by the same two observers.

Inhelder is conducting a further study of the growth of children in families where relatively frequent changes of principal figures take place, as in homes with nursemaids who change every year or so. The results will be interesting to compare with Bowlby's well-known description of the damaging effect of maternal deprivation on young children. The effects of maternal deprivation are currently being studied in Zurich at the Childrens Hospital, which is also carrying on some longitudinal studies using the Brunet-Lezine tests on infants. At the University of Genoa a group headed by Amedeo Della Volta is focusing on the psychomotor development of infants and young children. The group has considerable experience in Rorschach testing through the various phases of childhood. Genoa is the only university in Italy with an institute devoted entirely to child psychology.

A Norwegian group in Oslo headed by Gruda Skard has been carrying on a program since 1951 studying child development and parents' attitudes. Twenty-one families have been under study with the object of comparing the development of Norwegian children with that described in other countries, and to examine whether supposedly important factors causing difficulties in problem children have not also been present in the lives of supposedly normal children. After five years 18 families remain under observation. Results are not yet available.

In Paris, Irène Lezine is observing relationships between postmaturity and prematurity and mental development, and Odette Brunet is pursuing her longitudinal studies of the development of infants from birth onward.

Perception and Intelligence

In Geneva Jean Piaget is experimenting further with the evolution of perception, especially in respect to distance and speed. He is comparing the perception of children of different ages with that of adults, focusing principally on the relationship between perception and the formation and development of concepts and on the interaction between the two.



The doctor and boy he examines are participating in the Harvard-Florence research project in Italy. Selected boys in two schools are examined annually to assure continued likeness of pairs being compared for achievement.

Piaget, Inhelder, and colleagues have for a number of years also been studying the perception and classification of objects and pictures in children from 3 to 8 years of age. Having examined the merits of various hypotheses regarding the development of intelligence, they decided the matter was so complex that investigators must limit their field of study in order to obtain results. Thus they chose the field of object classification and are studying perception and its subsequent application when the child solves everyday problems. A book describing this work is in course of preparation.

In Eastern Germany K. Gottschaldt has investigated further the perception of numbers. With the child in a playpen he observed performance and behavior as the situation became more and more difficult.

The Tavistock Clinic group in London, with which John Bowlby is associated, has been studying, among other phenomena, the function of understanding in small children in the presence and absence of the mother.

Some of the studies of children's perception of art, especially those by J. Subes in France, indicate that in judging paintings of different styles children 5 to 7 years of age prefer abstract art, but when they become older they prefer realism. In the Soviet

Union the drawings of children are interpreted as an attempt to see reality and to present it clearly for others.

The Russians are also studying language development, and their results seem to identify language as an important factor in the function of concepts. In Moscow, A. R. Luria is interested in language as a social function and has been investigating the influence of language ability upon thought processes.

In Paris Odette Brunet and Rene Zazzo have examined language function in three groups of small children: (1) children from professional classes; (2) workmen's children raised by the mother; (3) workmen's children raised by a person other than the mother. These studies seem to demonstrate that acquisition of language skills decreases progressively in the 3 groups. That Zazzo is preoccupied by method is at once apparent to any reader of his critical paper on the use of twins for experimental work.¹

Jean Piaget has also conducted language studies and has come to the conclusion that in the child language follows thought but stimulates further elaboration of thought processes.

Bowlby is also interested in the development of language ability.

Personality Development

In Switzerland at the University of Berne, R. Meili is studying the personality development of 26 normal children from birth onward. This longitudinal study has now arrived at the 6-year point. Besides observing early individual differences Meili is giving special attention to the development of emotional behavior, with emphasis upon anxiety and frustration.

In Western Germany Hans Thomae at Erlangen University is continuing longitudinal studies on constitutional types. His particular interest is the possible relationships of acceleration and retardation in physical growth with the development of intelligence and personality. He has observed a general tendency toward higher intelligence and more mature personality in physically accelerated children and has identified varying maturation speeds in the factors which go into general development.

R. W. Parnell and colleagues at Oxford have been studying a number of children classified at the age of 7 according to physical type, and have observed a greater incidence of signs of emotional unrest in the ectomorphic (lean and fragile) type. The investi-

gators emphasize, however, that although the tendency toward unrest apparently continues in this group throughout childhood and the college years, a number of the most brilliant students come from this group.

In France, Zazzo, the originator of "Le Bestiaire" a test in which the child is asked to name, among other things, which animal he would like to be and which he would not like to be, is now emphasizing the importance of also asking the child what animals he likes and does not like. Confusion between the two ideas of what the child likes and what he would like to be must be avoided, he points out, to avoid difficulties in analysis.

School-Age Children

In Florence, the Harvard-Florence Research Project, in collaboration with the pediatric clinic and with the University Institute of Psychology directed by Alberto Marzi, has been studying the effects of progressive education upon personality development in elementary-school children. Paired children have been studied for periods up to 4 years, one of each pair being in the experimental group and the other in the control group. Physical condition, socio-economic status, age, educational level, and intelligence were used for pairing, the factors being controlled for constancy during the period. A number of projective and semiprojective tests were applied during the course of the research.

The paired children are students in two elementary schools—one run along "progressive" lines, where a certain amount of freedom in expression, behavior, and selection of activities is allowed, and the other run along traditional, didactic lines. The children in the experimental group attend the progressive school and the children in the control group, the traditional school.

While the results of this experiment have not yet been published, a preliminary analysis indicates that the progressive method of education has no marked influence upon development during an initial period which may extend up to 2 years. Thereafter, however, progressive education seems to stimulate increasingly the growth of certain features of the personality which many persons feel to be important for the development of social maturity. It does not seem to bring any advantages in respect to purely scholastic achievement.

Other activities of the Florence group include a fresh approach to school health. An experimental service has been set up to obtain a broad view of each

student, including such factors as intelligence, social maturity, socio-economic status, so that those not fulfilling reasonable expectations may be readily identified.

In London the National Foundation for Educational Research is proceeding with experiments² designed to examine critically Great Britain's present procedures for selecting children at the age of 11 for certain types of advanced education. This work originated in a suspicion that the potential of many children is being overlooked and that some are being selected who will turn out to be an unwise investment. The object is to help persons achieve their most appropriate place in a changing society in the kindest manner possible.

In Poland Alina Szeminska, who for some time has been investigating methods of selection for adoption and the placing of motherless children, is now studying a number of the problems presented by school children.

Behavior and Psychosis

Della Volta in Genoa is using a multidiscipline approach, including electroencephalographic examination, in following children with behavior difficulties. He has also studied alcoholism in children and its relationship with the same phenomenon in the adult.

James Anthony at the Maudsley Hospital in London has been studying object formation in psychotic children. While his work depends to some extent upon some ideas of Piaget, he has introduced some new and critical avenues of approach. He has observed that when, as occasionally happens, such children regress to the point where they are no longer capable of retaining the concept of object as something relatively unchangeable, they no longer suffer

anxieties such as those usually caused by separation from parents.

In Moscow, B. M. Teplov has been observing mentally defective children, focusing on their motor and cognitive development.

Liaison Needed

In the *Annual Review of Psychology* (1957),³ Inhelder has referred to the observation of Wayne Dennis of New York that while widespread concern with problems of education, personality development, and child rearing exists in most countries genuine experimental attacks upon these and related problems are extremely few. Dr. Inhelder suggests that liaison between child-study centers and psychology laboratories might be improved.

Such liaison might be developed not only within separate countries, but also on an international basis. There is no reason why the Atlantic Ocean should act as a barrier to such activities.

The author is indebted to Professor Inhelder for the quantity of valuable information she has made available during the writing of this article, and to Dr. James L. Whittenberger of the Harvard School of Public Health for his helpful suggestions. We hope this brief glimpse of what in reality covers a much wider and varied range of activities than can be described here will at least give some idea of the vitality and broad interests in experimental child psychology in Europe.

¹ Zazzo, R.: Sur le postulat de la comparabilite dans la methode des jumeaux. *ACTA Geneticae Medicae et Gemellologiae*, vol. IV, 1955 (p. 180).

² Yates, A.; Pidgeon, D. A.: Admission to grammar schools. National Foundation for Educational Research in England and Wales, publication no. 10. London: Newnes, 1957.

³ Inhelder, Barbel: Developmental psychology. *Annual Review of Psychology*, Volume 8, 1957.

"Wherever home is spelled with a capital 'H,' there will be the look in the eyes of the child. It is infinite longing and loneliness at first. A few years later, when disuse has atrophied even his capacity for affection, it is dull, stoical indifference . . . And it is this dull, stoical indifference that slumbers like dangerous dynamite within the institutional child. At first, when nobody cares for him, he is only sad. Later, when he cares for nobody, he is unsafe."

Mabel Potter Daggett, in *The Delineator*, November 1908

*Some functions in an over-all
community program of . . .*

CHILD-WELFARE SERVICE FOR THE MENTALLY RETARDED

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SOCIAL WORKERS have long recognized that social phenomena are vital factors in child development and that a child's problems and needs must be considered in relation to his environment—his family, his culture, and his community. Of these interacting forces, the child's relationship with his family has the greatest significance, for in the family his basic needs for love, security, and physical comfort must be fulfilled. While other social institutions such as churches and schools may contribute much toward the child's adjustability, their effectiveness depends largely on the extent to which their teachings are reenforced by the family. Since not all families discharge their responsibilities adequately, society has developed child-welfare services as one means of helping parents to provide their children with an opportunity for a satisfactory living experience.

In fulfilling these functions, public and voluntary welfare agencies have thus far largely neglected children handicapped by mental retardation. The needs of these children for diagnostic services, including pediatric, psychiatric, psychological and social services, special education, and training, comprise a major problem. This article will suggest

some of the ways in which child-welfare services as part of a total community program can more adequately help mentally retarded children and their families. Many of the considerations to follow are also applicable to other social workers.

Who Are the Mentally Retarded?

The American Association on Mental Deficiency defines mental retardation as "that group of conditions which is characterized by: (1) inadequate social adjustment; (2) reduced learning capacity; (3) slow rate of maturation."¹ These conditions may be present singly or in combination. They result from subaverage intellectual functioning which is usually present from birth or an early age. The association further defines mental retardation as "basically a symptom complex resulting from a wide variety of conditions including not only defects of the central nervous system but also those in the psychological and sociological spheres." It also points out that the psychological and social factors not only operate as causative mechanisms but may also play significant roles in influencing the degree and nature of mental retardation based on organic defect. This concept, in stressing the dynamic as opposed to the static elements in the condition, suggests that many mentally retarded children can be helped through treatment, education, or other thera-

Based on a paper presented at the 1957 Biennial Round Table Conference of the American Public Welfare Association.

peutic procedures even though the basic cerebral defect may not respond to remedial measures.

Because of the varying definitions used and the difficulty in applying the concept of social inadequacy, no accurate figures exist regarding the number of children or adults who may be classified as mentally retarded. It is safe to say, however, that those who fall into the lowest intelligence classification (persons incapable of achieving any degree of self-care) are a small minority of the total group. Comprising about 3 percent of all mentally retarded persons, many of them are physically as well as mentally handicapped. About 13 percent of all the mentally retarded are moderately retarded, semi-dependent, capable of self-care and the acquisition of simple work skills under sheltered conditions.

The remainder, or 84 percent of the retarded group, consists of persons who fall into the very broad and complex category of mild or borderline deficiency.² Many of these children have no demonstrable defect of the central nervous system. In some of these children poor intellectual functioning is due to social and cultural deprivation, superimposed upon a subnormal intellectual endowment. Their failure to adjust socially results partially (perhaps even primarily) from personality and behavior disorders resulting from environmental inadequacy, insufficient guidance and the negative effects of undesirable association.

Mentally retarded children with cerebral defect are born to families from every socio-economic class in society. On the other hand, children whose deficient functioning comes from a combination of sociological causes and poor endowment generally come from culturally and economically deprived families. In many of these families the child's retardation may be but one of a host of problems.

The tremendous variation in conditions of mentally retarded children is illustrated in the following cases:

Randy, a severely handicapped 5-year-old, has never been able to sit unsupported, cannot feed himself, is completely unresponsive, and is unable to communicate in regard to his most basic needs. The extent of Randy's handicap, the result of a birth injury, has been known to his parents since his early infancy. They were told at that time that the child would not live beyond 2 years of age and were advised to seek institutional care. State care, however, was not available for so young a child, and the family's moderate income was not adequate to afford private residential care.

The parents are intelligent people from an average socioeconomic background. The mother has a deep emotional investment in Randy despite his unresponsiveness. The burden of his care is a serious drain on her energies and she

is unable to devote sufficient time to the needs of her other child. Her chronic fatigue and nervous tension is a serious threat to the stability of the home.

* * *

Freddy, a 10-year-old Mongoloid child, is the youngest of 4 children. Psychological tests indicate that he functions at a 4-year, 3-month mental age level, can benefit from social habit training, and can learn simple tasks. The rural community in which he lives does not provide facilities of an educational or recreational nature for children with this degree of mental limitation.

Freddy is in good health, is not a behavior problem in the home, and is well accepted by his brothers and sisters. He has few opportunities for social relationships with children of his own age and occupies himself with simple household chores.

Freddy's father is a skilled laborer and earns an income adequate for the needs of his family. Although Freddy has not presented any unusual problems of care to this time, the parents are concerned about his approaching adolescence. They wonder, too, who will look after him in the event of their death.

* * *

Joan is an attractive, physically mature, 16-year-old girl, born out of wedlock. She has a history of petty theft and has occasionally demonstrated aggressive, hostile, and anti-social behavior. She lives in a deprived neighborhood with a high incidence of delinquency and associates with adolescents whose behavior is characterized by keeping late hours, drinking, and sexual promiscuity.

Joan's mother, who is of borderline intelligence, also has exhibited a degree of social inadequacy. She has entered into common-law relationships with several different men. Her work history is unstable so that she has had to receive public-assistance funds for a number of years. She has close emotional ties and genuine affection for her daughter. Her awareness of Joan's limitations and need for supervision is, however, dim.

Joan attended special classes in the public school system from the age of 8 until her exclusion at age 16, on the basis of having achieved her maximum education potential. She is able to read and write satisfactorily on the 6th-grade level, but has not yet developed any work skills.

Social Diagnosis

An integral part of the casework function in child-welfare service is a skilled appraisal of the capacities, limitations, and resources of a child and his family. In instances of mental retardation, when psychological and social factors may further limit inadequacies due to cerebral defects or other causes, a careful social diagnosis is of paramount importance. Limited intellect is but one of many factors which cause social insufficiency. Many persons of subaverage intelligence are socially adequate, whereas others of good intellect but suffering from neurotic disorders, psychosis, or personality defects, are not. It is not uncommon for children with mild retardation to develop some form of emotional disturbance which

further depresses their level of functioning. Equating mental subnormality with social incompetency ignores the importance of other factors and is not in accord with current knowledge on the psychodynamic aspects of human behavior.

Clinical experience suggests that some children regarded as mentally deficient are more emotionally disturbed than mentally impaired. Thus, early identification and diagnosis of children not functioning well are essential from a standpoint of prevention of retardation as well as of treatment. The child who is slow to respond to parental demands, retarded in his physical development, and unable to compete successfully with children his own age is particularly apt to provoke feelings of anxiety and frustration. Parents of such a child are likely to have feelings of guilt and self-doubt. The resultant intrafamilial tensions present an unfavorable milieu for the child's healthy personality growth.

Helping such parents to recognize and accept the fact that their child is retarded does more than alert the family to the child's special needs in home training and management or for a nursery school experience. It gives the parents an opportunity to adjust their goals for the child in accordance with his actual potentials, relieves them of frustration based upon unrealistic aspirations, and facilitates the development of positive relationships between the child and his parents as well as between the child and other members of the family. In this manner, the child's incapacity for social living may be limited only by his degree of intellectual retardation rather than also by a complexity of social and emotional disturbances.

Child-welfare workers are frequently in a position to help in this identification and diagnostic process. They know of such children in the caseloads of public welfare agencies on the basis of problems not directly related to the child's deficiency. Some of them are referred to them by the school, the juvenile-court judge, other social agencies, a neighbor, or a parent because of behavior problems or apparent neglect or abuse. Social workers need training in recognizing deviations from normal growth and development and in identifying the many factors which may cause a child to function at a subnormal level.

Diagnosis in a clinical or social sense involves in most cases the combined efforts of several professional disciplines, working as a team. The physician must determine the child's physical limitations, the eti-

ology of the disability, and the nature and degree of organic impairment; the psychologist must determine the child's capacity for learning, his special abilities or disabilities, the total personality configuration, and its implications for successful social adjustment; the social worker must determine, on the basis of the dynamics within the family, the extent to which family experiences have impeded or expedited social growth and the emotional and material resources of the family to meet the child's special needs. None of these factors can be readily determined on the basis of a single interview or examination. They emerge clearly only in a continuous form of evaluation.

So many factors may affect a child's rate of learning, maturation, or social competency that prognostic predictions, particularly during early childhood, are extremely hazardous. Many children identified as mentally retarded during their school years and thought to have limited potentials for economic productivity develop into stable and self-supporting members of the community. The child-welfare worker must maintain continuous contact with the family and keep abreast of its changing needs.

Problems of social and emotional adjustment may occur at every age and at every stage of development. Though other needs such as maternal and child-health services, special education, or vocational rehabilitation may assume primary importance for children in specific age groups or with certain handicaps, the family's need for help in providing the child with a successful social living experience arises in all groups and may play an important part in determining whether the primary service provided is effective.

Social Treatment

The major purpose of diagnosis is, of course, to offer a basis for the formulation of a sound treatment plan. What can the child-welfare worker contribute in a total service program?

The birth of a defective child is an extremely traumatic experience for every normal parent. In a child-centered culture such as ours the meaning of parenthood has deep ego significance. Parents are prone to make strong emotional investments in their child even before it is born. It is extremely difficult for them to give up the emotional gratifications anticipated from the social and educational achievements of a normal child and to avoid the feelings of guilt and shame that are apt to arise when the child is retarded. Such feelings are natural reactions to intense ego frustrations, but the frequent tendency to

explain parental behavior on the basis of these emotions alone is an oversimplification. Because all parents react differently to their children no matter what specific abilities or disabilities the children may have it is important to understand the parents' life experiences as children, adults, and parents, for these determine their reactions to their children, whether normal or retarded.

Parents are often susceptible to well-meant, but ill-founded, advice because of their own ungrounded fears and misconceptions regarding mental deficiency. They are frequently advised that other children in the home will be adversely affected by the presence of the retarded child. They may be told further that as the child matures into adolescence and adulthood, his child's mind will be unable to control the urges of sexual drives. Undoubtedly, many cases can be cited to support such contentions, but any approach to the mentally retarded as products of a single mold has little validity. The child's social competency depends a great deal upon the social demands made on him by his family and the community. Research regarding the social nature of mental deficiency indicates that in underdeveloped countries the mildly retarded are able to adapt to the social and cultural value system of their society, which is less demanding than ours.³

Adapting the Environment

One of the responsibilities of the child-welfare worker is to help create for the child as far as possible an environment in which the social demands made upon him are within the realm of accomplishment; where he is protected from situations dangerous to his welfare, yet not overprotected to the point where dependency is unnecessarily prolonged; where the attitudes of his parents and his brothers and sisters are accepting and understanding yet not overly sacrificing.

The child-welfare worker can help to create this therapeutic environment in the following ways:

1. Casework interviews with parents. These may be directed toward (a) interpreting the child's abilities as well as his limitations; (b) relieving parents of the anxieties, conflicts, tensions, and frustrations the child's condition arouses; (c) helping parents to solve marital or family problems that might be distinct from the child's handicap but which may impede emotional development.

2. Concrete assistance when needed. This may include making arrangements for financial aid to

the family or medical or nursing care. Some retarded children, because of extensive medical needs or their prolonged dependency, are an extreme financial burden to their families, but no child should be separated from his family on the basis of financial need alone. The emotional needs of retarded children are the same as those of other children. Moreover, institutional care may in the final analysis be more expensive to the community than direct assistance payments.

3. Arrangements for homemaker services. This is another resource the worker can call upon to preserve family strengths and unity. In many instances, freeing the mother from the burden of constant care and supervision of her retarded child, thus enabling her to meet the needs of other family members, may prevent family disorganization. In some families with retarded children homemakers may also be used effectively in a teaching capacity—demonstrating better methods of home management and child care to immature, inadequate, or retarded mothers who without such guidance may be unable to function satisfactorily as parents.

4. Arrangements for day care. Placement of the child in a day-care center, a family day-care home, or a nursery school appropriate to his needs often relieves pressures in the home. The mother may need help from the child-welfare worker in accepting such an arrangement as providing opportunities for growth for the child as well as relieving her. Frequently the child with mild retardation can be included in a group of normal preschool children.

5. Foster-family placement. This may have to be considered for some children whose parents, for varying reasons, cannot adequately fulfill their parental functions and responsibilities. While a child's sense of security is more likely to be maintained in his own family, in some circumstances removing the child from home is undoubtedly the wisest course. Where this means must be resorted to, the child is more apt to find emotional security in an intimate relationship with substitute parents than in the comparatively impersonal atmosphere of an institution. In addition to providing obvious advantages over institutions for social and emotional growth a good family atmosphere may stimulate the rate of learning in some retarded children.

Many retarded children have been placed in foster families by child-care agencies, but frequently the

agencies regard such placements as stopgaps pending institutionalization.

As we learn more about the meaning of separation to the child and his parents, the need to strengthen and preserve the family despite certain lacks in the home warrants greater emphasis.

6. Referral to group-recreation facilities. Such resources provide further means by which the environment can be better adapted to the needs of the retarded child and his family. Retarded children often lack the opportunity for normal social companionship. Having little status with their peers some of them seek recognition through antisocial or delinquent forms of behavior. Supervision of group activities by a skilled groupworker can frequently channelize otherwise destructive energies into constructive avenues of behavior, thereby increasing the child's happiness and sense of worth.

7. Arrangements for institutional care. For certain children this may be the most appropriate resource. The child-welfare worker can provide for continuity of service by participating in precommitment and postdischarge planning and followup services to children returned to their own or foster homes. Even where continuous custodial care is required, the family may continue to need help in adjusting to placement. Institutions should be considered as part of rather than separate from community resources.

Developing Social Competency

Along with the responsibility for adapting the environment, as much as feasible, to the needs of the retarded child the child-welfare worker has responsibility for seeing that the child receives help in developing greater social competency. The first step in this direction for the preschool-age child is through the development of motor skills, coordination, and other abilities that may eventually permit a reasonable degree of self-care. Helping the mother to further such developments is the function of a public-health nurse, occupational therapist, physical therapist, or child-development specialist. However, the effect of parent-child relationships on such training and the possible need to help siblings of retarded children with their feelings and attitudes about the child may call for direct service or consultation by a child-welfare worker.

Many retarded school-age children, particularly those with mild retardation, can profit from direct counseling services to themselves or their parents.

Some of them cannot make maximum use of their school experiences because of unfavorable home conditions, emotional disturbances, or hostile community attitudes. In such instances, the child-welfare worker, by virtue of his intimate knowledge of family dynamics, can provide the teacher with valuable insights regarding the child's behavior and learning problems, thus making it possible for her to plan an effective educational approach.

Since the success of a school experience for many children may also depend upon the degree to which knowledge and habits learned in school are reinforced at home, the child-welfare worker may need to serve as a liaison between the school and the family. She can help the family be aware of the teaching methods used, the abilities of the child uncovered at school and requiring continued development at home, and the forms of discipline to which the school has found the child to be most responsive. Not every child requires this special assistance, but where the emotional climate in the home is impeding the child's capacity to learn, the skills of the social worker as a "family specialist" can contribute a great deal.

Retarded adolescents in particular present a challenge to the caseworker. Many of them come to the attention of child-welfare agencies because of delinquent behavior or the need for protective services.

The theory that a person cannot be helped unless he initiates the request for help himself does not hold up in work with retarded adolescents. The social or moral judgment of some of these young people, as well as of their families, may be so impaired as to prevent them from making wise decision, particularly under stress. A child-welfare worker may sometimes need to be a retarded adolescent's superego, setting limits, offering advice, or making direct decisions. Though not made in reference to the retarded, Charlotte Towle's comment regarding "aggressive casework" is relevant:

"We no longer refrain from the use of authority, sometimes actually in the form of judgments as to right and wrong. To the extent that we use this authority in response to the client's need and his incapacity to appraise and regulate himself, rather than out of our own need to be authoritative, we are finding it a helpful measure. We support the client in many instances, more frequently than formerly, with advice and guidance, in response to his capacity to use it, or his incapacity to function without it."⁴

Assuming such responsibility for another person is a weighty obligation. It requires the caseworker

to have an understanding of the child's total personality, his special needs, the nature of his defenses, the social attitudes of the community, and his interaction with the environment in which he lives.

Retarded children need to be protected against exploitation, but they also need help in accepting the consequences of their own decisions, if they are able to make decisions and to profit by mistakes. In working with them a child-welfare worker must understand his own attitudes toward mental retardation and must guard against the pitfall of overprotection. He must help parents realize that the development of good judgment does not result from the passive acceptance of failure, but from facing up to unpleasant consequences. Michael F. Grapko has said of normal children: "The persons who succeeds in avoiding unpleasant consequences denies himself the opportunity for learning and growth."⁵ This also applies to the retarded.

The child-welfare worker can also help the retarded adolescent in developing good social relationships with the opposite sex, in finding opportunities for vocational training and employment and in budget management. Mildly retarded young adults may also need a social worker's help with the social-adjustment problems of moving into new living arrangements, working with persons with whom they may have little in common, and adapting their living habits to the authority of an industrial setting. Not all of the retarded can make the transition from school to employment, but professional guidance can help many to be assimilated into the general population.

Coordination and Research

Child-welfare workers can also stimulate and participate in community planning and social research in respect to the mentally retarded. There is an

urgent need for better coordination and utilization of existing resources in health, education, and welfare under public and private sponsorship. There is also a need for evaluation of ongoing programs, and stimulation of professional and citizens' groups into social action to eliminate gaps in services.

In collaboration with persons of other professional disciplines, child-welfare workers can also investigate the nonmedical aspects of mental retardation so that training and treatment techniques may be based on scientific facts rather than opinion. Greater concern in these areas by social workers and by schools of social work may spread interest in the potentialities of the retarded and provide a basis for more enlightened social attitudes and planning.

Thus, child-welfare workers and other social workers can play an important role in alleviating some aspects of the social component in mental retardation. Although medical research into the possibilities of preventing retardation has made notable progress in determining the causes and possible solutions in certain types of cerebral defect, for the present we must accept the fact that mentally handicapped children will be with us for many years to come. As with other health and welfare problems, social workers must deal with the present situation as well as the future in accordance with the best knowledge and resources currently available.

¹ American Association on Mental Deficiency, *Etiological Classification*, Part I, Fourth edition, Statistical Manual, 1957.

² Children and youth; their health and welfare. CB Pub. 363, Washington: U. S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau, 1958. Chart 8.

³ Clark, A. D. B.: A symposium: Social adjustment of the mentally deficient. I. Recent English research. *American Journal of Mental Deficiency*, September 1957.

⁴ Towle, Charlotte: New developments in social casework. Unpublished paper delivered at the annual meeting of Child Welfare Service, Illinois Department of Public Welfare, April 1957.

⁵ Grapko, Michael F.: The development of security in children. University of Toronto: The Institute of Child Study, June 1957.

The greatest inequality of opportunity in this country at the present time lies in the difference in the happiness or unhappiness of the homes from which children come.

Eileen Spelman, Case Conference, London, October 1957

HERE AND THERE

Settlement Workshop on Social Change

Expansion, strengthening, and revitalization of the settlement and neighborhood-house movement to meet needs created by rapid social change were strongly recommended by the participants of the 3-day action-research workshop carried out in mid-February under the sponsorship of the National Federation of Settlements, with funds from Lilly Endowment, Inc. Held at Columbia University's Arden House, Harriman, N. Y., the workshop brought settlement and neighborhood-house people from 25 cities together with consultants from the fields of sociology, anthropology, social work, economics, demography, city planning, and the arts to discuss social conditions challenging settlements today and to establish neighborhood goals in a rapidly changing world.

The conferees sought answers to such questions as: What are some of the major economic and social forces which will affect living conditions in the United States in the coming decade or two? What should be the role of neighborhood centers in the future? How can people engaged in neighborhood work develop new goals for neighborhood-serving agencies? How can attitudes conducive to creative approaches to new social conditions be strengthened among them? What further research is needed to throw light on these questions?

American community life, it was pointed out, has changed drastically in the last quarter of a century. The enormous turnover of population in inner-city neighborhoods has caught most cities unprepared. They now have fewer stable neighborhoods. Although the economic status of city people has improved, their cultural "poverty" is greater.

Population mobility came in for considerable attention. The discussion emphasized that many neighborhoods

where settlements now exist have become ports of entry for people who move out as soon as opportunity presents itself and that, therefore, settlement houses and neighborhood centers must work with people on the move, living in crowded conditions and in "pocket ghettos." The participants stressed the need for methods whereby people can be helped more rapidly to become a part of neighborhood life.

They also pointed out that in the families of these neighborhoods fathers and mothers usually are both working except in times of widespread unemployment when they are apt to be the first laid off and the last rehired; that in these neighborhoods schools are crowded and housed in old buildings, with poor equipment; that many children live in unhappy or broken homes; that many of them are part of so-called "hard-core, multiproblem" families.

The discussions revealed a variety of ways in which the settlements and neighborhood centers are trying to help families of such neighborhoods: through neighborhood councils; through intergroup projects in an effort to help the "hard-to-reach" youth groups; through short-term casework with individual families; through social groupwork to help meet needs of individuals through the group; through educational TV programs; through special work with handicapped groups, such as the mentally retarded, the blind, the aging; through family-life educational programs; through housing programs; and through arts and crafts.

The opinion predominated that in this day of changing needs the settlement because of its proximity and accessibility is indispensable as an agency for sorting out the troubles of people and providing some services not otherwise available to them. As one settlement worker said, "When they need you most they need you near."

The participants underscored the validity of the concept of neighborhood for many people, particularly for those

who are poor or troubled. They identified the substance of a neighborhood center as personal relationships. By providing such relationships, they said, the center helps to give people roots and a sense of identification. Thus it serves as an important mechanism for communication within a neighborhood.

A sense of urgent need for more fact-finding and research emerged during the workshop. The participants suggested a number of areas for research, relating to direct services, social movement and development, and recruitment and training of staff. In connection with direct services they identified a need for research on the "multiproblem" family, the adolescent, and the newcomer. Some aspects of social movement and development suggested for research were citizen participation, neighborhood organization, citywide or metropolitan organization, cultural bridging responsibilities, medical-care organizations, and intergroup relations.

The workshop, which was led by Wilbur J. Cohen of the University of Michigan, was planned to provide direction to the Federation and its affiliates in designing future program.

—Mildred Arnold

White House Conference

Late in March the House passed the appropriation bill containing the administration's budget request for 1959 for \$150,000 for staff and other expenses related to the 1960 White House Conference on Children and Youth.

March 1960 has been tentatively set as the time for the conference. In the near future a director for the conference planning will be named as will the members of a Presidential Advisory Committee.

In its role as initiator of conference planning the Children's Bureau has been gathering suggestions, to be passed on to the President's Committee, during the past year from professional and lay groups especially called together for the purpose or otherwise convened. The first of these meetings, held last September, was of an interim advisory group of 15 persons appointed by the 1956 Joint Conference on Children and Youth, sponsored by the Interdepartmental Committee on Children and Youth, the Council of National Organizations, and the National Council

of State Committees on Children and Youth. In February 1958 a small group of physicians and one of educators, speaking as individuals, made suggestions in 1-day meetings held in the Children's Bureau offices. Three organizations holding regular meetings in March devoted special sessions to the subject. These were the Education-Recreation section of the National Social Welfare Assembly, the Association of State Maternal and Child Health and Crippled Children's Directors, and the Joint Conference on Children and Youth.

All these groups strongly advocated that the Conference concern itself with ways of strengthening family life. Among the many specific questions suggested for conference scrutiny were:

How can families be helped which never set down their roots in any community? How can the planners of public and private housing be induced to take into account the needs of children and adolescents for a good home life? How can children and young people be encouraged to become both cooperative and independent? How can the "growth and development of parents" be nourished without undermining parents' self-confidence?

How can our education systems be geared to modern knowledge in regard to the effects of human relations on learning? How can the schools meet the needs of children who have special needs and still stimulate the creative potential in all children? How can children be helped to develop the attitudes, insights, and skills essential for international understanding? What is the teacher's function in our present culture?

Among areas suggested for factfinding were: accidents and poisoning; environmental contamination by man; perinatal problems; infections; prematurity; genetic and psychological factors in child development; health supervision of children from preschool age to maturity; and the problems and needs of adolescents.

At the 1958 Joint Conference on Children and Youth, Katherine B. Oettinger, Chief of the Children's Bureau, outlined the suggestions about the White House Conference received to date and, pointing out that conference attendance must be limited to 3,500, posed, among other questions, the following:

How can youth and parents, as parents, effectively participate in all stages of the conference? How can planning include both factfinding and action—at National, State, and local levels? How can widespread support for the conference be enlisted among persons who, because of space limitations, cannot be invited to participate in the meeting in Washington? How can democratic procedures and cooperative goals be assured?

In the ensuing discussion youth delegates to the Joint Conference urged that 30 percent of the delegates to the White House Conference be young people, two-thirds of these being "youth" or teen-agers, and one-third young adults. Another suggestion was for the appointment of an intergroup relations advisory committee to consider the Conference's possible contribution to the understanding of the impact of prejudice and racial discrimination on the growth of the child.

UNICEF

The Executive Board of UNICEF at its annual meeting in March decided to explore the area of aid to children in institutions and day-care centers to see if it is a suitable program area for UNICEF aid. Under the action, UNICEF is authorized to seek the help of the United Nations Bureau of Social Affairs and the maternal and child-health staff of the World Health Organization in developing a possible program to be ready for consideration at the 1959 meeting of the Board. If this type of aid were then accepted in principle, demonstration projects of a pilot nature might subsequently be considered by the Board for UNICEF support.

In making the proposal the United States representative, Katherine B. Oettinger, Chief of the Children's Bureau, said that the most universal method of care for children outside their own home is in congregate or specialized residential institutions, and that many infants and preschool children of working mothers are being cared for in day nursery and crèche programs in countries experiencing industrialization or otherwise needing the labor of women.

Pointing out that the kind of care these children get varies tremendously in both types of services, she added:

"The dangers of physical and mental

health are known to be very great for children living in institutions, particularly for long periods of time. In some countries an effort is made to develop adoption and foster family care for younger children, but in many countries institutional care will be the only means of providing for dependent and neglected children for many years. . . . There are many ways institutional care can be modified and improved so that it provides more adequately for children's physical, mental, and emotional needs; so that some of the benefits of home life can be preserved; and so that the child can be better prepared to enter into community life as an adult."

Physical Fitness

A plan for community action for promoting fitness in young people through the encouragement of physical activity has recently been released by the President's Council on Youth Fitness. Based on the premise that youth, being "naturally physically active," will respond to opportunities to plan and participate in sports and other physical activities, the statement urges communities to: increase, where needed, the number and variety of existing sport activities; emphasize health and nutrition education; make greater use, for physical activities, of existing public and private facilities, such as schools, recreation centers, and parks; provide high-quality adult leaders in sufficient number for the fitness programs.

Against Polio

In view of new evidence that children 1 to 4 years of age are more susceptible to paralytic polio than those of any other age group, the Public Health Service is urging special efforts to have children under 5 years of age vaccinated against the disease. The American Academy of Pediatrics and the American Academy of General Practice are joining the campaign to protect the under-5 age group.

Preliminary figures compiled by the Public Health Service's Communicable Disease Center show that in 1957 1-year-old children had the highest attack rate for paralytic polio—5.7 per 100,000 children a year old. The next highest rate—5.5—was among 2-year-olds. For all children through the age of 4 the rate averaged 4.4, compared with 1.4 for the 5-through-19 age group and 0.8 for persons 20 through 39.

The figures show also that the large majority of paralytic cases occurred in nonvaccinated persons.

The campaign is part of a larger one, in which the Public Health Service, the American Medical Association, the National Foundation for Infantile Paralysis, and other groups are promoting vaccination of all persons through the age of 40 with the Salk vaccine.

The National Foundation for Infantile Paralysis recently granted funds totaling more than \$1 million for poliomyelitis research and treatment. Part of the grants for treatment will be used to establish two new poliomyelitis centers at universities.

Among the projects covered by the research grants are work on a new surgical technique to halt scoliosis, a curvature of the spine; studies of swallowing, respiration, and speech after an attack of bulbar poliomyelitis; and electric activity of the brain in children with contagious diseases.

Mental Health

A number of States enacted legislation in 1957 to increase State and community mental-health programs and services for emotionally disturbed and mentally retarded children.

Four States—California, Minnesota, New Jersey, and Vermont—passed laws providing grants-in-aid to localities for community mental-health services such as mental-health clinics, services for emotionally disturbed and mentally retarded children, rehabilitative and aftercare programs, and public education in mental health.

Laws authorizing counties to levy taxes or to appropriate funds for supporting local mental-health centers or clinics were passed by Iowa, Kansas, and South Dakota.

Arkansas, Nebraska, and Texas authorized construction of new institutions for care and treatment of the mentally retarded. Idaho and Minnesota made it mandatory for local school districts to provide instruction for handicapped children. The State of Washington authorized establishment of a diagnostic and training center for the mentally retarded and a research and treatment center for emotionally disturbed children.

Minnesota authorized a residential treatment center for emotionally disturbed children; New York, an institu-

tion for research in mental retardation. California authorized its Youth Authority to establish a special program of intensive treatment in two institutions for juvenile delinquents.

North Dakota's legislature provided for training stipends for psychiatric personnel for the mental-health agencies of the State.

Health Studies

Factors in each maternal death in four regions in California are being analyzed as a step toward safeguarding pregnancies and saving mothers' lives. The investigation, which was begun in August 1957, is being carried on jointly by the State medical association, the State department of public health, and local health departments in those regions.

Before beginning to collect the data a committee of the association defined four regions in the State in which the number of maternal deaths per year was about equal, and appointed a study committee in each, including an obstetrician, an anesthesiologist, a public-health physician, and a pathologist.

Whenever a local health officer in one of these regions files a death certificate mentioning pregnancy, he sends copies to the regional study committee. An obstetric consultant employed by the State health department then interviews the physician who attended the mother who died; with the attending physician's permission he also reviews her hospital record. The regional committee reviews all the factors involved in the death from the point of view of future efforts to prevent such deaths.

Statistical services for the study are provided by the State department of public health.

The U. S. Public Health Service, in cooperation with the Insular Department of Public Health, is studying Puerto Rican adults found with untreated oral clefts. A pilot study, made in Puerto Rico last June, suggested that much valuable knowledge about the management of oral clefts could result from the study of untreated cases at maturation. An intensive case-finding effort is now underway and the Public Health Service team will begin their main study of these cases next May in Puerto Rico.

The first nationwide study of reactions to the principal antibiotics shows

a substantially greater incidence of reactions to penicillin than to other drugs in this group, according to the Food and Drug Administration, Department of Health, Education, and Welfare, which made the study.

One-third, or 1,070, of the reported reactions to all antibiotics were classed as life-threatening; of these, 900 were reactions to penicillin.

Though case histories indicate that physicians have not been using penicillin indiscriminately, the FDA suggests that before it is administered to a patient there should be a clear-cut indication of need. It is not possible, the FDA noted, to determine absolutely that an individual will or will not suffer a reaction to the drug.

The study covered the period from the latter part of 1953 to early 1957, and showed that during this period serious reactions to penicillin have been increasing each year. Copies of the complete study report will be made available to the medical profession.

Inservice Training

With a grant from the Rockefeller Brothers' Fund the American Public Welfare Association is conducting a 3-year project to help State and local public welfare agencies in developing their social-service programs. As part of the project, two training institutes have already been held, one in January 1958 on the objectives of public administration and the leadership role of the public welfare administrator, and one in March on preventive and protective services for children. Future institutes will take up such subjects as medical-care administration, staff-development program objectives, research for now and for the future, and the county department of welfare as a service agency. As part of the project the association is also planning to publish material for use in program development.

Last February the New York City Board of Education and a voluntary agency, the Jewish Child Care Association of New York, initiated a 15-session seminar for employees of the city school system who teach in institutions for dependent, neglected, and emotionally disturbed children. Thirty-five teachers have been enrolled.

The seminar includes discussion of the definition of emotional disturbance in children; the components of a pro-

gram for institutional treatment; the circumstances that lead to placement of children in institutions and other types of placement; the use of psychological and remedial services in overcoming learning blocks; the psychological development of the child and the origins and signs of deviant behavior; the role of cottage parents and recreational workers in institutional treatment; and the place of the school in the treatment program.

The National Council for the Gifted, an organization formed last November in West Orange, N. J., has announced plans to work with educational systems in developing programs from nursery school through college for children who have unusual ability in specific areas. The organization will focus on encouraging business concerns, industries, and the professions to cooperate with schools in developing educational activities—in school and elsewhere—for such boys and girls; to help prepare teachers for work with the gifted; to encourage research and experimentation in the education of the gifted.

Radiation

A National Advisory Committee on Radiation was recently appointed by the Surgeon General of the Public Health Service to advise him and the Service's new Division of Radiation on further development of programs dealing with public-health aspects of radiation from all sources. Present activities of the Service, planned to safeguard the public against the hazards of radiation, include: helping the States to develop programs for reducing the amount of radiation to which people are exposed; training professional personnel for health work concerned with radiation; basic research on the effects of radiation on man; study of public-health methods for monitoring the amount of radiation in such media as soil, milk, water, and air; developing methods for reducing these amounts; and epidemiological studies of radiation-induced disease.

Juvenile Delinquency

The Senate, by a resolution enacted January 29, 1958, has authorized expenditure of \$75,000 for investigation of juvenile delinquency in the year ending January 31, 1959, by the subcommittee to study juvenile delinquency, of the Committee on the Judiciary (S. Res.

237). According to the report that accompanied the resolution, the subcommittee plans to concentrate on the following areas: training schools for delinquents; policies of the Armed Forces with regard to inducting former delinquents; a community plan for handling delinquency problems, produced as a result of hearings held in New York City; probation, parole, and juvenile courts, including violation of the rights of children in juvenile courts; and methods of dealing with delinquent and incorrigible children in public-school systems. The subcommittee will conduct hearings on legislation coming under its jurisdiction (Report 1206).

The Community Welfare Council of Minneapolis, Minn., is carrying on a study that will continue for at least a year to find out whether the social adjustment of members of delinquent youth groups is appreciably improved through the efforts of "floating workers" from social agencies; and whether the efforts of such workers improve the attitudes of significant individuals in the delinquents' neighborhoods.

Two neighborhood houses are collecting information on changes that take place in the actions of the members of six delinquent groups with regard to disorderly conduct, offenses against property and against persons, and traffic offenses. Data on the boys and girls—13-17 years old—will be gathered concerning their conception of themselves and of others; their evaluation of their school, family, and community; and their employment records. Information will be sought on group atmosphere and on organization of delinquent groups and their activities. Selected persons in the neighborhoods, such as churchmen, businessmen, and educators will be asked about some aspects of change in the community climate.

Six other delinquent groups, living in the same general kind of area as the groups being studied, but some distance away, are serving as controls.

As a step toward helping training schools for delinquent children further evolve from custodial to treatment institutions, the Children's Bureau, with the Rutgers University Graduate School of Social Work and three associations of training-school administrators, jointly sponsored a workshop

held at New Brunswick, N. J., March 30-April 5, 1958, to examine administrative problems arising from inservice staff training in institutions for juvenile delinquents. The workshop, which grew out of a similar 5-day workshop held in April 1957 with help from the American Legion Child Welfare Foundation, was supported by a grant from the Ford Foundation.

The three associations participating as sponsors were: the National Conference of Superintendents of Training Schools and Reformatories, the National Conference of Superintendents of Girls' Training Schools, and the National Association of Training Schools and Juvenile Agencies.

As with last year's workshop, which was reported in a Children's Bureau publication, "Staff Training for Personnel in Institutions for Juvenile Delinquents," a report of this year's is expected to be issued.

A 3-year study of problems and practices in institutions for delinquent children is being carried on by the New York School of Social Work's research center with a grant of \$130,000 from the Ford Foundation. The purpose of the study is to discover the effects of various types of human relationships on rehabilitative efforts, especially: (1) How the children's own codes of behavior and social structure affect their participation in the institutional activities; (2) how the points of contact between the children's life in their own social structure and in the institutional program can be used to influence their social concepts; (3) how staff relationships and structure affect the children; (4) how institutional programs can be affected by external pressures; (5) how social changes can be made in institutions when the children's needs require them.

Codirectors of the study are Lloyd E. Ohlin and Richard A. Cloward.

Proxy Adoptions

Because of a great increase in recent years in adoptions by proxy of children from overseas, the Child Welfare League of America and the International Social Service, American Branch, are jointly undertaking a preliminary survey of the extent of this practice and the problems it has created.

In a proxy adoption, a foreign child while still in his own country becomes the legal child of adoptive parents in

the United States. With few exceptions the adoptive parents have not seen the child before he is brought here. No requirement exists for a determination of the fitness of the parents by a court in the United States, or for investigation of them by an authorized social agency. Because the adoptive parents do not appear in the foreign court but are represented by a proxy, it is possible for them to know little or nothing about the child they are adopting.

Through the survey information will be gathered from member agencies of the Child Welfare League and from State public welfare agencies about proxy-adopted children and their adoptive families, in an effort to determine the need for new Federal legislation or for a broader study of what is happening to these children.

Last November the executive committee of International Social Service meeting in Paris adopted a resolution pointing out to national authorities responsible for child welfare and the proper bodies of the United Nations the possibility that adoption by proxy may violate the rights of the child. The resolution asserted that ISS experience with adoptions had demonstrated the importance of "the most careful social study possible, particularly when children are adopted outside their country of residence."

The ISS's American branch has recently issued a statement identifying four safeguards in adoption procedures which are lacking in proxy adoptions: Careful preparation for termination of parental rights; social-agency determination of suitability of the new family and home for the child; social-agency determination of the child's adoptability; a living-together period for family and child before adoption is final. The statement is accompanied by 16 brief case stories of proxy adoptions, all of which ended in tragedy.

WHO Assembly

The first meeting of the World Health Assembly, the governing body of the World Health Organization, to be held in the United States since the establishment of WHO in 1948 is convening at the end of May in Minneapolis, Minn. Among the Director General's proposals for WHO's 1959 work to be considered are WHO's program in the peaceful uses of atomic

energy, including cooperation with the International Atomic Energy Agency. For 2 days before the business meetings the Assembly will observe WHO's tenth anniversary with a special session reviewing the Organization's work.

Mental Retardation

As a step toward sharing information on operation and management of clinics for mentally retarded children, State directors of maternal and child-health services and clinic directors of special projects for the mentally retarded met in Washington March 24-25 at a conference called by the Children's Bureau. Fifty States and Territories were represented among the 124 persons present.

Participants described methods used in some of the programs to tabulate clinical data and discussed possible efforts to extend such procedures to all of the clinics. Consideration was also given to the possibility of agreeing on a standard system of nomenclature and classification of types of mental retardation.

Suggestions on clinic management made by the conferees related to, among other subjects, waiting lists and priorities; evaluation of a child's condition; interpretation of the condition to parents; and research activities.

Among many clinic needs expressed by the discussants, the one most emphasized was the need for a clearinghouse to share records of unusual cases; review and abstract literature, provide lists of available publications and information on grants, study courses, and meetings; develop more adequate clinical record forms; and possibly to coordinate study projects. The group decided to set up committees to explore further the needs of mental-retardation clinics and to suggest ways of fulfilling them.

Two companion reports surveying research into the causes of mental retardation have been issued recently under sponsorship of the National Association for Retarded Children. One, written by a physician, reviews research on physical factors that lead to damage of the nervous system, preventing development of normal intellect; the other, by a psychologist and an anthropologist, examines studies concerned with the influence of environment on mental development.

The report on studies of physical causes, prepared by Richard Masland, M. D., summarizes the results of investigations of genetic and other defects existing before birth (the cause of an overwhelming majority of cases of retardation); of injuries to the nervous system around the time of birth; and of diseases of infancy and childhood. It notes that with some disorders a baby may be born susceptible to some condition that will affect his mentality only when the condition is combined with unfavorable environment factors.

Recognizing the contribution of psychiatrists to the management of the mentally retarded, the author urges that the medical profession as a whole take more interest in establishing multidisciplinary programs for retardates. Such programs are lacking, he says, partly because both the public and the profession feel that the mentally retarded are not the concern of the physician. He attributes this attitude to the "undeniable fact" that in most cases of retardation medical treatment has little to offer, a fact which emphasizes the importance of dealing with the social and educational problems, especially those of the less severely retarded.

The report recommends that new training schools for mentally retarded children be placed near university medical centers and that medical schools include diagnostic facilities for the mentally retarded.

The report on the influence of environment on retardation was prepared to encourage social scientists to view mental retardation as an important research area, according to the authors. Seymour B. Sarason, Ph. D., and Thomas Gladwin, Ph. D. Stressing the importance of social and cultural factors in mental development, this report recommends a number of steps toward finding the causes of retardation. Among the measures are: cross-cultural research to test hypotheses regarding genetic, dietary, metabolic, and other factors in mental development; longitudinal studies of the familial and social milieu in which retarded children live; and studies to identify the mental ability needed for minimally adequate life in the community.

The two reports, first published separately, will soon be available in a joint edition from the National Association for Retarded Children.

IN THE JOURNALS

Social Agencies and Courts

The juvenile court from the point of view of a social worker and of a judge is discussed in two articles in *Child Welfare* for March 1958. ("The Social Worker and the Court," by Naomi Grossman, supervisor of court service for the Jewish Board of Guardians, New York City, and "The Court's Authority," by Henry G. Sweney, President Judge, Delaware County Court, Pa.)

In her article Mrs. Grossman urges social caseworkers to recognize the court for what it is—a public judicial agency, not a casework agency, though she notes that the court's work may be the first step in getting help to families "so caught in the morass of poverty, deprivation, and dependency that they cannot move forward." Social workers, she says, must learn that the court is neither a treatment resource nor a bugaboo.

Judge Sweney describes cooperation between the judge and social agencies in treating two kinds of cases: families still living together but functioning poorly, and broken families requiring temporary or permanent placement of children. In both kinds of cases, the author says, he finds it important to make clear to the family the legal rights and responsibilities of the parents and the power of the court to remove the children. He finds that such understanding is likely to lead to success when the caseworker tries to help the parents plan for the children's future.

Court Commitment

Most of the children brought before juvenile courts do not need the total rebuilding job offered by correctional institutions, says Thomas D. Gill in the January 1958 issue of the *National Probation and Parole Association Journal*. Rather, he maintains, the vast majority need only the help that can be given through probation. ("When Should a Child Be Committed?")

The author, who is judge of the Con-

necticut State Juvenile Court, defines the child who needs removal from the community as the one whose behavior is persistently antisocial and seriously affects other people, who shows continuing defiance to adult authority, and who has been unable to benefit from probation. Many such children can be helped by a modern correctional school, the author says, but if their difficulties stem from inner tensions they may belong in special treatment centers for the emotionally disturbed. He also points out that some children who are psychotic, mentally retarded, or otherwise organically damaged should not be placed in a correctional school because such a school cannot help them properly and because their presence in the school would impede its efforts to help the children who belong there.

If facilities are not available to take care of children who need special care the juvenile-court judge should crusade to obtain them, the author maintains.

Vs. Rheumatic Fever

A low-cost program for reducing the incidence among school children of rheumatic fever and other diseases that follow streptococcal infection is described in two articles published in the *Journal of the American Medical Association* for March 8, 1958. ("The Casper [Wyo.] Project—an Enforced Mass-Culture Streptococcal Control Program: 1. Clinical Aspects; 2. Technical Aspects.") The article on clinical aspects of the program is by Brendan Phibbs, M. D., chairman of the rheumatic-fever control committee of Natrona County Medical Society; Donald Becker, M. D., pathologist of the county hospital; and seven other physicians. The technical aspects are described by Dr. Becker, Dr. Phibbs, and Charles Lowe, M. D.

The program, which is carried on in the primary grades of all the schools in the city, is reported as follows: Every school day teachers refer all children who seem ill or who complain of sore throat or a cold to volunteer workers trained to inspect them for symptoms

of streptococcal infection and to take throat cultures of suspected cases. Those whose cultures are positive are excluded from school until they have been treated by their family physicians at least 24 hours. Free penicillin is available from the State department of health to families unable to pay for it. Every private physician in the county has responded "vigorously and intelligently" to the demands of the program, the authors note.

Figures cited show that the program has produced a significant lowering of the incidence of streptococcal infection among this group of more than 6,000 children and appears to have reduced the incidence of new cases of rheumatic fever and acute nephritis.

Parents of Epileptic Children

Three members of the staff of the seizure clinic of the Los Angeles Children's Hospital have for the past 3 years been meeting regularly with groups of parents to answer their questions and otherwise help them to lessen the tensions arising from their child's condition. An account of these meetings, reported by the pediatrician, the psychologist, and the social worker who conduct them, is published in the March 1958 issue of the *Journal of Pediatrics*. ("Group Sessions for Parents of Children With Epilepsy," by Gaston J. Baus, L. LaVergne Letson, and Edith Russell.") The course consists of five weekly sessions of an hour or an hour and a half. The group is kept small enough to make round-table discussion and interruptions possible.

At the first two sessions the pediatrician, who is also an epileptologist, gives the parents medical information; he describes the different kinds of seizures and their frequency and duration and teaches the parents how to take care of a child during a seizure. He discusses the principles of treatment of epilepsy, emphasizing that the medications used are not habit forming. The third and fourth sessions, conducted by the psychologist, are aimed at helping the parents with emotional problems, such as the fear that correcting the child will bring on a seizure. The social worker, at the final session, focuses on the child's social relationships and tells the parents about community resources such as school programs for epileptic children, camp facilities, and groups interested in the disease.

BOOK NOTES

THE LOUISVILLE STORY. Omer Carmichael and Weldon James. Simon & Schuster, New York. 1957. 169 pp. Cloth, \$3.50; paper, \$1.

How the schools of Louisville, Ky., integrated their Negro and white pupils successfully into their classes is described in this book by the city superintendent of schools and a member of the editorial staff of a local newspaper.

Factors in the success of the change are listed as: (1) A long period of good racial relations and interracial adjustment before desegregation of the schools began; (2) prompt and clear-cut acceptance of the Supreme Court's decision in the segregated school cases as the law; (3) immediate announcement after the Court's "how and when" ruling that it would be carried out without delay or subterfuge; (4) preparation of pupils, teachers, and the community for the coming changes; (5) full cooperation of city and county officials and coordination of the city's plans with the county's; and (6) a friendly press.

Among the features of the desegregation plan adopted by the board of education 9 months before the schools' opening day in September 1956 the book lists: Every school in the city and every grade—kindergarten through adult classes—to admit both white and Negro pupils; new school districts to be formed, without regard to race and without unnatural boundaries; each school to serve the children in its area as conveniently as possible, without excessive travel for any child; parents of each child to be informed in writing of the school or schools where their children belong; transfers to a school preferred by a parent to be granted insofar as possible.

PSYCHOTHERAPY OF THE ADOLESCENT. Edited by Benjamin Harris Balser. International Universities Press, New York, 1957. 270 pp. \$5.

In this book a number of psychiatrists present various aspects of treatment of adolescents in difficulty. They discuss,

for example, psychotherapy of adolescents in psychiatrists' private practice; at school; in clinics; as inpatients in hospitals; and in several combinations of these, such as at school plus inpatient hospital treatment. The book also presents a verbatim 20-minute tape-recorded interview between an 18-year-old boy and a psychotherapist, annotated with interpretive comments by the therapist. One chapter, by a school principal, presents a schoolmaster's view of the normal adolescent as a "somewhat disturbed person requiring at least a mild and continuous therapy from parents and teacher."

NEW UNDERSTANDING OF LEADERSHIP; a survey and application of research. Murray G. Ross and Charles E. Hendry. Association Press, New York. 1957. 158 pp. \$3.50.

In this book the authors, both university officers and former professors of social work, discuss types of leaders and theories of leadership, summarize a large number of research studies on the nature and meaning of leadership, and offer a tentative program for developing leaders.

THE PLACEMENT OF ADOPTIVE CHILDREN. J. Richard Wittenborn, assisted by Barbara Myers. Charles C Thomas, Springfield, Ill. 1957. 189 pp. \$4.75.

Reporting on a follow-up study of a number of families with adopted children the authors, a professor of psychology and a research specialist in psychology and sociology, recommend several steps for the improvement of adoption agency services.

The authors address themselves to two questions: (1) How accurately and in what respects can the Yale Developmental Examination of infant behavior be employed to predict future development for adoptive children? (2) What characteristics of adoptive placements may be shown to be correlated with characteristics of adoptive children?

In regard to the first they report that their data do not indicate any useful predictive value for that examination. In regard to the second, they produce comparative data on the Binet I. Q. scores and such traits of the child as "aggressiveness" or "maturity quotient" in relation to the background of the child's true parents, similarities between adoptive parents and adoptive children, "matching" of adoptive parents and children, independent and social-agency placements.

In their conclusion the authors recommend methods for a long-term and widespread investigation to determine the relative importance of various aspects of child care for an adopted child.

NO AND YES: On the genesis of human communication. René A. Spitz, International Universities Press, New York, N. Y. 1957. 170 pp. \$4.

This book reports on a section of a continuing study of the genesis of communicative efforts in infant development. It deals with the inception of semantic and symbolic communication, the beginnings of thought processes, and concept formulation. The entire study is psychoanalytically oriented, its purpose being to substantiate through research some of Freud's most basic theoretical formulations.

DELINQUENCY; sickness or sin? Richard V. McCann. Harper & Bros., New York. 1957. 179 pp. \$3.

This book is based on a study begun at the Harvard Divinity School in 1954 to determine what greater role religion might play in preventing juvenile delinquency. A seminar in delinquency was organized. As an integral part of this, theological students went to detention centers, clinics, probation departments, and other agencies to work directly with delinquent youth and get to know them.

To obtain comparable data about each delinquent youth an interview guide was developed which could be used flexibly and informally by students to discover whom they admire, the degree of their emotional outreach, and the nature of their goals. It was found that most delinquent boys and girls interviewed either lacked any self-concept or had an inadequate or distorted self-image. This inadequacy was traced to the absence of meaningful adults in

their lives. This was the main clue pursued by the study staff to determine why the traditional moralistic church approach often fails to reach children in trouble or to prevent delinquency. Suggestions for action by clergy, parents, and laymen are included.

CHILDHOOD AND ADOLESCENCE; a psychology of the growing person. L. Joseph Stone and Joseph Church. Foreword by Otto Klineberg. Random House, New York. 1957. 456 pp. \$6.50.

Planned "to convey a more accurate understanding of children," this textbook, by two members of the faculty of Vassar College's Department of Child Study, is chiefly devoted to examination of facts concerning psychological development of the child from conception through adolescence. It also describes some deviant forms that development may take and some of the disturbances of normal psychological functioning that may arise during the growing years. Finally, it defines the field of

child study and shows how such study has evolved, notes some of the methods that have been used in finding out about children's development, and sets forth some of the problems that need to be solved.

THE YOUNG HANDICAPPED CHILD; educational guidance for the young blind, cerebral palsied, and deaf child. Agatha H. Bowley. With a section on *The Young Deaf Child*, by L. Gardner. E. & S. Livingstone, Edinburgh and London. 1957. 128 pp. Available from the Williams & Wilkins Co., Baltimore. \$3.50.

Emphasizing development of initiative and independence in the handicapped child, this book offers concrete suggestions to parents and teachers of such children.

LOGIC AND PSYCHOLOGY. Jean Piaget. Introduction by W. Mays. Basic Books, New York, N. Y. 1957. 48 pp. \$1.50.

This book is based on three lectures delivered in 1952 at the University of

Manchester in which the author shows how the techniques of symbolic logic may be applied to the study of the intellectual development of the child. It is a technical research publication directed specifically to highly trained specialists in child psychology and related fields. An explanation of Piaget's system of symbolic logic is contained in the introduction.

CHILD CARE AND TRAINING. Marion L. Faegre, John E. Anderson, and Dale B. Harris. Eighth edition, revised. Prepared under the auspices of the University of Minnesota Institute of Child Development and Welfare. University of Minnesota Press, Minneapolis. 1958. 300 pp. \$3.

This eighth edition of a book first published in 1928 has been revised in the light of recent research and current theory about child development. It includes two new chapters: on accidents and on personality adjustment.

GUIDES AND REPORTS

MENTAL GROWTH AND PERSONALITY DEVELOPMENT: A LONGITUDINAL STUDY. Lester W. Sontag, Charles T. Baker, and Virginia L. Nelson. Monographs of the Society for Research in Child Development, Vol. 23, Serial No. 68, No. 2. 1958. Child Development Publications, Purdue University, Lafayette, Ind. 143 pp. \$3.

Reports on changes in mental ability in 140 children, and on personality, familial, and physical factors associated with such changes.

TEN MILLION AND ONE; NEUROLOGICAL DISABILITY AS A NATIONAL PROBLEM. Preface by Leona Baumgartner. Paul B. Hoerber, New York. 102 p. \$3.50.

A report of a conference sponsored by the National Health Council. Includes discussion of the cost of neurological disability to society and to the individual; diagnosis and treatment of the disabled person; development and

dissemination of knowledge about this type of disability; preparation of the patient for mature existence; and research.

A COMPARISON OF BRAIN-INJURED AND NON-BRAIN-INJURED MENTALLY RETARDED CHILDREN ON SEVERAL PSYCHOLOGICAL VARIABLES. James J. Gallagher. Monographs of the Society for Research in Child Development, Vol. 22, Serial No. 65, No. 2. Child Development Publications, Purdue University, Lafayette, Ind. 1957. 79 pp. \$2.50.

Reports on a study in which matched groups of 24 brain-injured and 24 familial mentally retarded children were compared on measures of perception, learning aptitude, intellectual scatter, language development, quantitative ability, and personality characteristics. While differences were found between the groups primarily on personality variables, the range of prob-

lems encountered casts doubt, according to the author, on the wisdom of treating the brain-injured as a homogeneous group either for program planning or research.

SCOUTING WITH HANDICAPPED BOYS. Boy Scouts of America, New Brunswick, N. J. 1957. 64 pp. 75 cents.

Describes how boys can participate in Scout activities, even though blind, crippled, deaf, mentally retarded, or otherwise handicapped.

STEPS FOR TODAY TOWARD BETTER MENTAL HEALTH; pointers to action for all who give health services. Report of the 1957 National Health Forum. National Health Council, 1790 Broadway, New York 19, N. Y. 1957. 118 pp. \$1.50.

Includes discussions on: the promotion of mental health in the family, in the schools, and in industry; in-service training in good mental-health procedures for health workers; and community self-study of mental-health needs and procedures; and an analysis of the causes of mental illness by a panel brought together by the Joint Commission on Mental Illness and Health.

READERS' EXCHANGE

OHLIN: *Treatment implications*

Dr. Ohlin dramatically demonstrated but left unstated what is perhaps the most significant contribution of his article: *Diagnoses of "personality disorders" must be made in organizational rather than individualistic terms.* ("The Reduction of Role Conflict in Institutional Staff," by Lloyd E. Ohlin, *CHILDREN*, March-April 1958.)

Certainly it has been traditional to assume that "uncooperative" behavior among institutional staff members is a personal characteristic of the individual exhibiting the behavior. In institutions for treatment personnel policies are almost always based on this assumption. If a nonprofessional worker does not cooperate with the professional staff it is common, for example, to diagnose him as a "rigid," "punitive," "neurotic," or even "sadistic" personality. Such diagnoses are followed by efforts to change him through education and therapy, or by dismissal.

Professor Ohlin has effectively shown that an alternative theory of personality calls for quite different kinds of diagnoses and, consequently, quite different personnel policies. The personality theory he uses has long been buried under an avalanche of variations on Freudian theory. It is time to dig it out. Fundamentally, and in much oversimplified form, the theory maintains, in the words of Dorwin Cartwright (*Human Relations*, 1951), that "how aggressive or cooperative a person is, how much self-respect or self-confidence he has, how energetic and productive his work is, what he aspires to, what he believes to be true and good, whom he loves or hates, and what beliefs or prejudices he holds—all these characteristics [are] in a real sense the properties of groups and of the relationships between people."

Dr. Ohlin's article shows conclusively that many traits exhibited by individual staff members are properties of the organization, not of the person in

question. From this observation, it follows logically that if the traits are to be changed the organization, not the person, must be made the object of modification. This is what was done in the experiment the article describes, the first of its kind so far as I know; and it worked.

We should no longer talk about "sadistic" men seeking out jobs as policemen or institutional workers. Rather, we should ask what organizational structures are present in police departments and institutions to produce action which we define as sadistic. The essential notion, again, is that one who is involved in an organization that "owns" certain kinds of behavior will exhibit those kinds of behavior.

There are also implications for dealing with the inmates, not the employees, of the institutions. How easy it is to attribute a fight between two inmates to personal traits such as "aggressiveness," "latent hostility," or "hot temper." Alternatively, we should ask: "What is there about the institutional organization which produced a fight?" Once this is answered we can ask, further, whether this can be changed and, significantly, whether it is desirable to change it. Conceivably, organizational modification to eliminate the fights could have as its consequence the elimination or modification of other conditions which we hold dear.

There are implications, too, for theories of delinquency and crime causation. By far the most popular notion in this area is that delinquency is a personal trait, "owned" by the delinquent. It is usually viewed as a symptom, to be sure, but as a symptom of something belonging to him, not to his group (organization). However, we might view delinquency as the property of groups in the same way that we view institutional staff attitudes as the properties of organizations. It would follow that rather than providing therapy of a type designed to modify individual personalities we would use therapy de-

signed to modify the groups owning the behavior the delinquent is exhibiting.

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Preparation for change

In his article on role conflict in cottage staff, Dr. Ohlin touches upon the key problem of institutional administration.

Unless institutions come to grips with the conflicts and anxieties of cottage staff, they lose all possibilities of communicating treatment concepts. Role conflict is not only engendered by a correctional organization's changing from a custodial to a treatment orientation, as described by Dr. Ohlin, but is inherent at all institutions in the cottage-parent role itself.

Cottage staffs come to institutions with fixed ideas concerning eating, grooming, washing, cleaning, use of language, and other elements of behavior. Confronted with delinquent standards, the tendency for the staff member is to react in terms of his own life experience. Clinical considerations which call for individual differentiation are apt to create conflict and anxiety in him in direct proportion to the strength of his fixed ideas. A cottage parent whose standard for cleanliness is two baths a day can become quite upset when faced with the suggestion that for a particular girl or boy a shower every 2 days might be all that could be expected.

It was primarily to help cottage parents with such problems through a close supervisory relationship that the new treatment structure described in Dr. Ohlin's article was organized at the New York State Training School for Girls. In analyzing this experiment, Dr. Ohlin says: "The relatively untroubled smoothness with which the new integration (of casework and home life departments) has occurred suggests that the basic accommodations

which formerly existed between the girls' informal organization and the official system have not been materially altered."

I would like to make a few comments in regard to this statement:

1. Dr. Ohlin is incorrectly assuming that the control problems described to him as having existed in the school in 1953 had continued until eliminated by the introduction of the new integrated program in 1956. His hypothesis would be valid if the program had been introduced in 1953. However, gross misbehavior and control problems had largely been resolved at the institution before the introduction of this program.

2. An intermediate step had taken place during the previous 2 years. Case-workers during that period were assigned to cottage units to carry a caseload but without cottage-staff supervisory responsibilities.

3. Integration did not occur as smoothly and as effortlessly as the statement implies. Cottage groups were analyzed by the social-work supervisors and administrative staff. Some transfers and other staff changes were made. The basis on which new girls were assigned to cottages gradually changed with increased knowledge of the group composition and with more awareness of the ability of individual staff members to work constructively with particular girls. In this way we not only achieved better group balance but developed the cottage parent's ability to work with girls presenting a greater variety of problems. More staff time, education, and understanding became available to the girls. They received more opportunity for individual expression within the group. More help has been offered them individually and in groups for channeling drives positively.

4. Dr. Ohlin is probably referring to the experimental group incentive program in our vocational and academic schools. This is another project, requiring a paper in itself.

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STRÖMGREN: *The importance of genes*

It was a pleasure to read this article by Erik Strömgren based on his address to the World Federation of Men-

tal Health at Copenhagen. ("Genetics and Mental Health," CHILDREN, March-April 1958.) With increasing knowledge about the continuous interaction of genetic and nongenetic components of man's makeup in all periods of his life, psychiatric research workers seem at present to be less inclined than ever to minimize the effect of gene-specific metabolic processes in the organization of normal and abnormal behavior patterns, irrespective of the various levels of personality integration on which their interests are focussed.

It would seem essential, however, to point to a few formulations in Dr. Strömgren's report which may lend themselves to misinterpretation:

1. If mental-health work has been correctly defined as having "the goal to cure and to prevent mental disorders insofar as possible," it is clear that genetic studies, the aim of which is to search for basic causes in specific types of mental disorder, do not conflict with general psychiatric objectives.

It is a well-established fact that a gene exerts its action in a given area or environment, which in turn is largely the product of evolutionary development and genetically controlled interaction. If science, aided by the penetrating clues provided by genetic research, ever succeeds in unravelling this complex process and thereby helps in developing direct treatment procedures for so challenging a condition as schizophrenia, it would not be justified to say that "the genes . . . would lose their importance." Actually, the opposite would be true.

2. The twin-study method, if applied properly, provides a unique opportunity of investigating intrafamily variations with a minimum of uncontrolled variables, especially with respect to traits that present complex sampling problems and require comparisons in both cross-sectional and longitudinal directions. Dr. Strömgren characterizes the method as "weak" because "the environment may be more similar for the monozygotic twins than for the dizygotic twins . . . [It] will tend to treat identical twins in an identical way whereas the obvious differences between nonidentical twins will release different reactions from it.

This view would seem to disregard the fact that different reactions elicited from the mother in the early postnatal

period will be caused by primary behavior differences in the infants rather than by the effect of hearsay reports on their zygosity (one-egg or two-egg). As to later personality development, psychodynamic concepts are also compatible with the premise that man being selective in respect to important aspects of his life can be thought of as "creating his own environment" (Alexander).

3. In his comments on homosexual behavior Dr. Strömgren states overt homosexuals can be divided into psychopathic and psychoneurotic groups.

The various mechanisms by which a postulated "gene-controlled disarrangement in the balance between male and female maturation tendencies" (Kallmann) may result in overt homosexual behavior have yet to be clarified. On the other hand, in line with Dr. Strömgren's own stated convictions, the presence of "obvious and convincing . . . psychological mechanism" expressed as a "serious life conflict" would neither rule out the operation of a genetic factor nor require the establishment of separate clinical groups. Instead, such research data and working hypotheses as have been provided by Kallmann's investigations should focus attention upon the entire developmental process in question and spur the organization of joint research projects combining the methods of demography, psychodynamics, physiological genetics, and chemistry.

As Dr. Strömgren indicates, such interdisciplinary approaches are most likely eventually to provide adequate insight into normal and extreme variations in human behavior.

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